Medical Alumni Bulletin

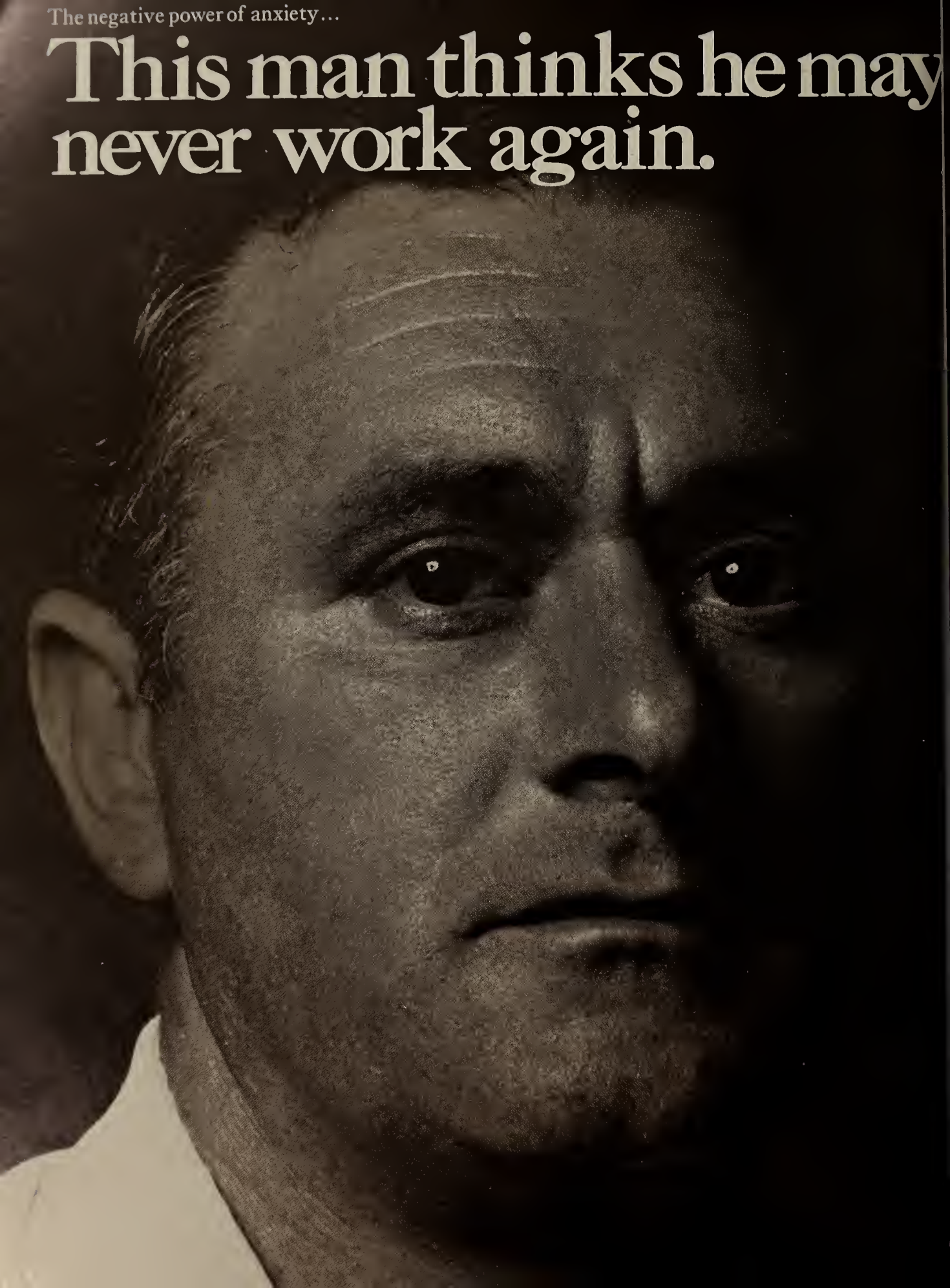
HARVARD

July/August 1970

F. Sargent Cheever '36, President
Harvard Medical Alumni Association

The negative power of anxiety...

This man thinks he may never work again.



The patient who has had a myocardial infarction is usually advised by his physician to avoid emotional excitement. All too often his family, acutely concerned, transmits its anxiety to him, urging him to "rest, rest."

How anxiety may interfere

In a study of 336 males who had suffered at least one myocardial infarction, Sigler[1] reports that manual workers showed the lowest percentage of patients returning to work, compared to clerical workers, business and professional men. The author notes that in many cases the mere apprehension that "return to work would shorten life prevents the patient from resuming activities." It is also well known that emotional disturbance is probably the most common cause of cardiac disability in postinfarction cases.[1]

The anxiety factor in both *coronary* and *precoronary* patients has recently been discussed by Thomas,[2] who suggests: "Intensive investigation of the sources and kinds of anxiety, and how destructive forms of anxiety can be identified and relieved may be the next important step in the prevention of coronary heart disease."

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References: 1. Sigler, L. H.: *Geriatrics, 22*:(9) 97, 1967. 2. Thomas, C. B.: *Johns Hopkins Med. J., 122*:69, 1968.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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Townsend, E. H., Jr.: New England J. Med. 258:63, 1958.

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Langdon Parsons '27

DESPITE the turmoil in the world and on college campuses across the country, there is reason for optimism at Harvard Medical School. The optimism is based on the superior lines of communication that have been established, which, in large part, have been due to the outstanding work of the Student Faculty Committee.

Although there has been such a committee at HMS for many years, the most important decision they have addressed themselves to was where to hang the portrait of the retiring dean. Rather than hang himself, Dean Ebert had the foresight to reactivate this committee and put it to work. It is not a committee created to meet a situation; it serves in an advisory capacity. Members have spent long hours in thoughtful deliberation and, in my opinion, their labors have been highly productive. Many factions are represented; no one group has been played down, yet no group dominates.

For obvious reasons, attendance today is low. Rarely has the expression "thank you for coming" meant more. We would like to make this Alumni Day a particularly memorable one. We will try to close the credibility gap by attempting to give you a clearer picture of what is going on at the School today, and in particular, why it takes the expression it does.

I imagine many of you are as confused as I am about much of what is going on today. Some things I do not approve of; others I am in sympathy with, but disagree with approach and tactics; and in many areas, I find myself in complete agreement. But I am never quite sure where I belong. Perhaps you would like to establish a firm position and not be like the man in the play who finally could not stand his wife's outburst:

"Are you a man or a mouse?"

"Isn't there something in between?" he sadly questioned.

After these discussions, you may find your rightful place.

Dr. Parsons opens the morning program.

Governance and the Faculty

Thomas H. Hunter '40

Vice Chancellor for Medical Affairs
University of Virginia Medical School

WE are in a revolution in this country and anyone who expects business as usual had better depart, because it is not going to be business as usual anywhere, including a university or medical school. Universities are right in the middle of the revolution. My hope is that it will be a revolution in the sense of the industrial revolution — a change in our way of life, a drastic change in the way men think about things — rather than in the sense of our bloody revolution of independence from Britain.

There is a critical role for the university in the revolution. If universities are unable to move with the times, and to appreciate the winds that are blowing, we are in for serious trouble. Why should the university be central to this? Because reason must prevail. Kingman Brewster has said, "If not reason, what?" If reason is to prevail, certainly the university needs to be strong and needs to defend its basic values in the face of various pressures. Universities must keep their values straight, because the revolution of which I speak is a revolution of values. Young people have rightly questioned their perception of many of the fundamental values they think our generation has stood for, or has not denied.

I am reminded of a profound observation made by Paul Tillich when he first joined the Harvard faculty in the 1950's. He told the Board of Overseers that all teachers in the university should introduce the religious dimension into their teaching. We thought, "Is Harvard becoming a source of dogma? Are we going to be preached at from every podium in every class?" There was a great furor because we misunderstood what Tillich meant by the religious dimension in teaching. Later I had the opportunity to ask him what he had meant. He said that every teacher, no matter what he taught, should give his students evidence of his concern for ultimate values, and the relation of his teaching effort to ultimate values. Tillich anticipated by 15 years what in large measure is going on today.

What bearing does this have on governance and particularly on faculties? Have faculties been selfish? Have they been looking out for their own interests? I hesitate to make generalizations from one institution to another, but I have reason to be-

lieve that faculties do have certain things in common, and the times in which we live allow some generalizations to be made.

In discussing faculties and governance, I would like to distinguish academic freedom from academic license. We all believe that academic freedom should be stoutly defended; it is one of the essential prerequisites of a liberal university. But freedom, by absolute necessity, implies responsibility. There is no freedom without the assumption of responsibility.

Faculties cannot expect freedom in the sense of license, which I define as freedom without any implied special responsibility. In certain instances, various faculty members have behaved as if academic freedom allowed them to do precisely what they wanted to do, when they wanted to do it, under their own terms, without so much as a "fare thee well" to anyone. These individuals fail to realize that they are ultimately responsible to their students, to the university, and to society. This is a valid criticism of only a limited number, I realize.

Such behavior has not seriously marred the teaching effort in most universities, but it has led society to question the whole concept of academic freedom. One of the responsibilities of all faculties, including medical faculties, is the responsibility for Tillich's religious dimension in teaching.

This is what the students are requesting. They ask, "*Why* are we doing this?" not, "*What* are we doing?" They ask, "Can we afford to go on doing it and survive?" If faculties are to survive, they must find the answers to these questions.

One of the central issues facing us today is that society and mankind are in a bind on the issues that were brought to light during Environmental Week. People have begun to realize that we are on a collision course with many disastrous events in the world. The main enemy of man is man himself, but we do not know how to deal with ourselves. We deal effectively with rockets and technological super machinery, but we are very poor indeed at dealing with human and social problems. These intractable, difficult survival matters must be dealt with effectively, or we are literally not going to survive.

Most of the talent that exists today that might possibly produce some solutions to these problems resides in our universities. By no means, all of it. Our problem is how to mobilize the best brains to work on the problems that really matter without some type of coercive-fascist, "you do this" and "you do that" kind of direction, that would misdirect them anyway.

How can we have the freedom of inquiry that is needed in an open academic environment? How can we re-order things in such a way that talent is attracted to the problems that really matter? Students want this chance. But there are few opportunities for them because we have tended to go where the living is easy. We tackle problems with built-in solutions and pre-existent methodology, move in, and win a Nobel prize! We shy away from the problems that are the real "stinkers." If the methodology is poor, we sweep the problem under the rug and hope someone else will manage it.

Society asks, "Who is going to do it, and when?" and "Are they going to do it in time?"

It is incumbent on all of us to move the rug, face the problems, and find the solutions.

Dr. Hunter

Governance and the Teaching Hospital

F. Sargent Cheever '36

Vice Chancellor for Health Professions
University of Pittsburgh School of Medicine

MEDICAL schools and teaching hospitals, those institutions that make up the guts of our university health centers, face enormous problems, challenges, and opportunities today. These are well known to you but nonetheless, let me mention a few of the most obvious.

The need to develop new and more effective methods of treating and preventing disease in the face of static or even shrinking funds for medical research.

The need to develop more effective means of educating the practicing physician, the medical scientist, and a variety of paramedical personnel, such as dentists, nurses, pharmacists, medical technicians, hopefully while reducing cost and time requirements.

The need to devise and implement new and better methods of delivering comprehensive health care, which will be available as a right to all people regardless of the ability of the individual patient to meet the bill.

All this, and much more, must be accomplished in the face of rising costs, loss of status of the medical profession, and the growing mistrust on the part of urban communities for their indigenous medical centers because of the latter's real or presumed lack of interest in their local problems.

If we are going to meet these

Dr. Cheever

challenges, we must work out an effective method of cooperation between hospitals and medical schools.

If the university owns its hospital or hospitals the task of devising common goals and policies for the two or more institutions is difficult enough, but it is much harder when the medical school and its affiliated hospital or hospitals are independent in their governance, administration, and their financial structure, as is the case here in the Harvard community and in Pittsburgh, another area with which I have some familiarity. But in both systems, i.e. medical school — university hospital and medical school — independent-yet-affiliated-hospital complexes, this development of common goals and policies must be accomplished if we are to have any chance to solve the problems facing us now, not to mention those which we can see dimly appearing on the horizon of the next decade.

In recent months I have acquired three strong prejudices dealing with faculty, trustees, and institutions, respectively.

First, the principle that is going to hold teaching hospital and medical school together, and make each great, is a simple one — before a physician becomes a member of the active staff of an affiliated teaching hospital, he must have an appointment on the faculty of medicine. This helps the hospital because it insures the professional caliber of its staff. It helps the individual physician because it makes him aware of his dual responsibilities for patient care on the one hand, and for the training of medical students, interns, and residents on the other. It helps the medical school because it makes the faculty of medicine directly responsible for the clinical teaching programs in the affiliated hospital.

Second, some method must be devised for getting the boards of trustees of independent yet affiliated institutions to work together. This is a formidable task because the university and its affiliated hospitals have dedicated, hardworking, effective trustees who take immense and justifiable pride in what they are doing. It is often difficult for them to realize that sometimes the whole is really more important than the sum of all its individual parts. Here one seeks to combine the strongest elements of the two systems; pride in and loyalty to a part of the whole, joined with a real sense of responsibility for the development of the entire center. Various approaches to the solution of this problem have been tried. One possible method of achieving this goal is the appointment of interlocking trustees who are members of both university and hospital boards. A more promising line of attack is the formation of committees for planning and policy-making that have representation from both the board of the hospital (or hospitals), and from that of the university. Again it is an enormous challenge for these individuals to realize that although they represent a particular institution, they must temporarily sacrifice a certain amount of their allegiance and assume corporate responsibility for the entire health center.

Third, if health centers are going to work well in the future, it is imperative that teaching hospitals and medical schools design new, imaginative, and effective administrative setups for delivering community health care on a comprehensive basis to the areas surrounding them. I have come, reluctantly, to the conclusion that medical schools are not the ideal institutions to deliver comprehensive health care directly. Teaching hospitals are better equipped, but even here there are inherent deficiencies. There must be immense input, both individually and collectively, from the faculty of medicine and from the teaching hospital in such an endeavor, but this must be channeled through a new administrative complex that will take the direct responsibility for the delivery of comprehensive health care to the community surrounding it. It must draw on the resources of community hospitals and public health agencies as well as on those of the university medical center. To be effective the new administrative complex must have consumer representation in planning and in governance from the start, with the consequent development of primary loyalty to the community.

It is obvious that the development of any program that delivers comprehensive health care to the community has vast implications and opportunities for the teaching of medical students, the training of interns and residents, and for experimentation with new methods of health care. But medical schools and teaching hospitals are delicate institutions because of their responsibilities for the next generation of physicians and patients. If they are to be successful in carrying out their functions in teaching, in research, and in training, they must have administrative protection from the very justifiable, but absolutely endless, demands and needs for the delivery of medical care. They cannot do everything. Working together the teaching hospital and the medical school can make a major contribution to a comprehensive medical care program but the primary responsibility must rest with a community oriented administrative complex which, truly representing consumer interests, can draw on wider resources as well.

Governance and Community Relations

Isaac M. Taylor '45

Dean, University of North Carolina School of Medicine

For many reasons a medical school must assume community responsibilities and establish community identity. Unless it does so, it cannot avoid a quality of artificiality that vitiates the purposes of the school.

I take it as a first principle that medical schools must have clearly defined roles in clearly identified communities. The primary purpose of a medical school is the education of young men and women for the practice of medicine. A second (but not secondary) purpose is to conduct research relevant to human health and welfare. It is in fulfillment of these purposes that the medical school's relation to the community becomes clear.

The clinical education of medical students, interns, residents and fellows must take place in an environment that is totally relevant to community need. In the early 1940's, when I was in medical school, the Boston City Hospital was a popular place for clinical training because it clearly served the needs of its community. It was a vital, virtually indispensable part of the community and medical students, interns and residents knew that their participation was essential for the care of patients who presented themselves to the hospital. Knowing that one is needed is an indispensable ingredient of the learning experience. If our teaching programs are to be vital and meaningful, we must assiduously guard against artificiality. We cannot play games. This is what students are telling us when they insist on relevance.

That word, relevance, is one I hesitate to use because these days it has become almost hackneyed. It is so important, though, that it is unavoidable. We are at a time in our nation when we must examine the relevance of all our institutions.

In the early 1940's and before, metropolitan hospitals, voluntary or public, provided the entire range of medical services needed by their communities. In the context of the times and of the then current art and science of medicine, they were "comprehensive health centers." As such, they provided an adequate setting for learning medicine. Nowadays the hospital alone does not provide the whole range of medical services and hence alone does not fulfill the need of educational programs. Today, outpatient departments, public health centers, store-front community health centers, doctors offices, group practices, nursing homes, rehabilitation centers, chronic care institutions, private homes, as well as acute care hospitals, are part of the health care establishment of a community and must become part of the educational setting. What the medical school needs today is a teaching community, not merely a teaching hospital.

Once more, relevance is the key. The student (and the teacher) must be able to identify himself as a meaningful part of the community health delivery system.

Basic science departments also have a responsibility to society and to the community, although the qualities of this responsibility are more difficult to define. One form of community involvement of a medical school is the development of new knowledge through research and this responsibility falls heavily on the basic science departments. Teaching by basic science departments in the medical curriculum must be relevant to the major purpose of the medical school, that is, the education of physicians. Because of scientific advances in the last 25 years, it has become increasingly difficult for the basic science departments to select for medical students those portions of each discipline relevant to medical practice. Nevertheless, it must be done. If basic science departments isolate themselves from the problems of human biology and human disease, we must ask whether they do not properly belong in parts of the university other than the medical school and whether it might not be better to include some of these disciplines in the premedical curriculum.

I would like to mention two responsibilities that a medical school cannot and should not assume. First of all, I do not think a medical school can perform its primary function if

Dr. Taylor

it assumes responsibility for delivering medical care beyond the needs of the educational programs of the school. For example, it would be inappropriate for a state medical school to operate the state's department of mental health, or to be responsible for providing health care to all indigent patients of the state. The academic function of the medical school would be impaired if it were asked to assume health service delivery responsibilities on such a scale. We must assume primary responsibility for the delivery of services in our teaching hospitals and in community programs but only to the extent these services are necessary for the teaching program itself.

Second, I do not believe that a medical school or a university as such has the responsibility to act as a political instrument. The crisis faced by our nation today is as severe as any it has ever experienced. We lie between anarchy on the one hand and fascism on the other. All citizens should be gravely concerned about the preservation of personal liberty. Many citizens have concluded in good conscience that they should suspend all their normal activities and give full attention to finding a solution to our nation's problems. These citizens have my full sympathy and support, but I do not think the university or the medical school is the instrument through which and by which these individuals should expect to undertake effective action. It is inevitable and proper that those of us who work in medical schools discuss the grave problems of our society in our work, in our offices, in the laboratories, in the lecture halls informally and in meetings of faculty, students and staff. In my opinion, however, it is manifestly unwise to ask the medical school as such to take position on political questions beyond its purposes and responsibilities.

During the Council meeting on 28 May, the HMS Strike Steering Committee requested, and was granted, time on the morning program during Alumni Day. The following is the speech of their representative.

Why We Strike

David Spiegel '71

I was doing my medicine rotation at the Boston City Hospital until a month ago when I stopped. I will try to explain why I and people like me in the Harvard Medical Area are taking time from our ordinary interests to work against the war and repression.

In the wake of the Kent State murders several hundred employees, students, faculty, and administrators met in Amphitheater D on Tuesday, 5 May. They voted to strike in support of five demands. First let me explain why I am here. A group of similar size met the next day and elected a strike steering committee. I am a member of that committee and was asked by them to speak with you.

What I would like to do is share my perspective of what is going on in this country, and why I felt compelled to do what I did.

A quote I keep in mind is one by Eldridge Cleaver. He said, "If you're not part of the solution, you're part of the problem."

The first demand voted by the group was:

> That the United States government cease its escalation of the Vietnam War into Cambodia and Laos; that it unilaterally and immediately withdraw all forces from Southeast Asia.

I have been deeply disturbed about the war for a long time — many of us have. But why should medical people meddle in the affairs of state? There are two reasons. Being a doctor or a health worker does not exempt us from our status as human beings. The blood of that war is on my hands — on our hands. Every acre defoliated, every prisoner tortured, every man, woman, and child killed in the name of protecting us is killed in our name. Even if the domino theory were true, is our virtue so great that it is worth the blood of hundreds of thousands of Vietnamese people to protect us? Further, we are fighting in support of a military dictatorship and against the government that the people of Vietnam want. Our second reason for meddling is that we have devoted our lives to the alleviation of suffering and the prevention of illness. Preventive medicine has always taken a back seat among medical fields, but is it not strange that we spend days and weeks trying to prevent the death of one patient when we don't seem to consider it our function to prevent the thousands of useless deaths that go on every year in our name? It isn't Nixon's war, it's our war.

And now, in the face of rising clamor for peace, they are killing Cambodians as well as Vietnamese for us. While Nixon promised to get the troops out by the end of June, the Defense Department has been dropping hints that in fact our airplanes will be supporting the South Vietnamese troops in Cambodia, and that our advisors will remain there. The South Vietnamese have made it clear that they have no intention of getting out of Cambodia. After so many years, we are spreading the slaughter in support of another repressive military dictatorship. So once again, this is our war; this is something that concerns us all.

The second demand voted was:

> That the United States government end its systematic oppression of political dissidents and release all political prisoners from such groups as the Black Panthers, Young Lords, Patriots, Student Nonviolent Coordinating Committee, and others who speak out against war and racism.

I think this part is particularly important. Many of you may find it hard to believe what I am about to say. If you do not believe what I say, please at least believe that I believe it and that this has come hard for me. Let me take you on a street tour of this country during the last two years.

Three black students were murdered by state police while ordered to lie on the ground at Orangeburg, South Carolina, in 1968. There was a police riot that summer in the streets of Chicago; Hoffman's follies have not masked the fact that no policeman or mayor was indicted for inciting to riot. I went to Chicago as a medic and I was appalled. I grew up with perhaps the same notion as you did — the policeman is your friend and if you talk nicely to him, he will talk nicely to you. I tried that with one policeman and I got a baton across my back. From what I saw there it became clear to me that this government could be used as an instrument of destruction as well as protection. It is up to us to protect ourselves and the rest of the world from our government.

Fred Hampton and Mark Clark, two Black Panther leaders were shot in their beds in Chicago. The police claim that the Panthers attacked them was so flimsy that last week the District Attorney dropped charges against the seven other Panthers who were arrested for supposedly attacking the police at 4:30 in the morning from their bedroom. I guess they're supposed to be grateful.

Bobby Seale, chairman of the Black Panther Party, went to New Haven to deliver a lecture at Yale University in Battell Chapel. He was subsequently charged with four counts of kidnapping and murder that supposedly occurred during his visit. The only evidence against him is the testimony of another defendant, George Sams, who is mentally deficient, has been institutionalized for a number of years, and made the accusation while in police custody.

Twenty-one Panthers in New York have been held in jail for over a year with bail of up to $100,000 each, on charges of:

> Conspiring to murder New York City policemen and to dynamite five mid-town department stores, a police precinct, six railroad rights-of-way and the New York Botanical Gardens.

The New York Botanical Gardens! One of those held in jail is a colleague of ours. Dr. Curtis Powell is a biochemist engaged in cancer research at Columbia Presbyterian Medical Center. He has been held for over a year in $50,000 bail. His wife, who was six months pregnant at the time of the arrest, had a premature delivery shortly afterward. He was denied permission to visit her in the hospital even after their child died. His salary was cut off when he was arrested and his wife and two other children have had to apply for relief. He received an honorable discharge from the armed forces after serving in Korea and had no previous police record. A final irony is that while his bail has been set at $50,000, several white men who were arrested in New York on charges of actually bombing several department stores have bail set at $25,000. That is half what his bail is and one quarter of the bail of most of the other Panthers.

Not only are doctors not immune, neither is Boston — the Cradle of Liberty. Walter Duggan of the Boston Police Department recently murdered two patients and injured a third on an orthopedic ward at the Boston City Hospital. Although he was the only armed man in the room, and the patient who supposedly made a move toward him had his arm in a sling after a dislocation of his shoulder, Judge Adlow cleared the officer of any wrongdoing in emptying his revolver into the patient. Not only did he murder the patient he shot at, he severed the spinal cord of a patient who was lying in traction across the room and who died a week later.

Two weeks ago Boston's Tactical Police Force swept an area near Northeastern University on Hemenway Street where block parties had been held peacefully for the previous several nights. They ran down the street yelling, "Kent got four, we want more." They beat a blind musician and his wife as he sat on his doorstep playing a flute. They broke into apartments not only of students, but of older citizens living in that area and destroyed furniture, beat up several Northeastern University officials who were trying to maintain peace, and threw rocks at students from rooftops. This story was not covered in the Boston newspapers although the Northeastern students covered it in their paper and on their radio stations. For the first several days, in spite of the students' pleading with the *Boston Globe* and the *Herald Traveler* to print the story, they refused. Finally, through a friend of theirs, it was picked up by the *New York Times* and used on the front page. At that point the *Boston Globe* decided maybe they should print it after all.

Mr. Spiegel

If you were just thinking "Well at least those Black Panthers deserve it," please remember two things. First of all, no one deserves it. If the police can choose to make exceptions about individuals' civil liberties and lives, then you or anyone else could be the next exception. Second, we only hear about the Panthers when they are shot at. That's the only kind of press they seem to get.

In fact, they spend most of their

time working on free breakfast programs for ghetto children, fair housing committees, and free health centers. The Panther-sponsored People's Free Health Center in Boston, which many of us have been working on, will open on Sunday (31 May) to give basic screening tests, simple medical care, and act as a referral center to other medical facilities. They expect the police will try to close the center, and a group of citizens who live in the housing project across the street have formed a defense committee to keep a permanent vigil over the center.

The Panthers do plan armed self defense. This is a concept that is hard for us to understand, because most of us have absolutely nothing to do with the police or get on with them in a sort of marginally pleasant way. But if you at least believe that I believe what I have just told you, then consider what the Panthers should do when the police raid their headquarters at Oakland and Denver and every major city in this country. What should they do when the police come in shooting? Call a policeman? It makes you realize how desperate this situation is. Twenty-eight Panthers have died at the hands of police since the founding of the Black Panther Party. These people find it necessary to arm themselves for self defense. The question is, who is responsible for something like this happening?

The third demand was:

> That the universities immediately end defense research, ROTC, counter-insurgency research, and all other such programs.

The critical concept here is the myth of neutrality of universities. A university is not neutral because it says nothing about political issues. Silence implies consent, and as long as the things this government is doing are allowed to go unchallenged by any group, that means they agree with it and the responsibility lies with them. To say that universities are not assisting the military by doing their research and training their officers is like saying a scrub nurse is not assisting at an operation. At the meeting whose vote I am reporting, Dr. Ebert stated that Harvard Medical School is doing no defense research. He did later state that several Harvard medical researchers are funded by Defense Department grants. Those men should be funded, but why through the Defense Department? The Pentagon has harmed health care enough already by robbing it and medical schools of funds. Should the Pentagon be allowed to direct our research as well?

The fourth demand:

> We condemn the murder of students by the National Guard at Kent State University, and also condemn the clear-cut presidential policy of intimidation and of prevention of expression of constitutionally guaranteed rights to assemble and dissent.

The stage had been set. Our Vice-President had talked about how dissenting students could be separated from society as easily as taking "rotten apples out of a barrel." President Nixon referred to us as "bums." Four days later, four of us were dead and eleven other "effete intellectual snobs" were wounded. Was it a tragic mistake? The black people of Augusta don't think so, having seen six of their brothers shot in the back. Then black students at Jackson State were murdered. There will be more dead black people, more dead students, unless we make it painfully clear to our government that we cannot tolerate the murder of dissenters, we cannot tolerate the intimidation of dissenters, we cannot tolerate government intolerance of dissent.

The fifth and final demand is long and I will summarize it. It states the group's determination to strike in support of the previous four demands, asks that there be no reprisals against members of the strike, and asks President Pusey to express our condemnation of the Cambodian invasion to President Nixon. There was much concern that we strikers would irresponsibly leave patients to die in their beds. That certainly happens enough normally, such as on the nights when there is one nurse assigned to cover eight wards at the Boston City Hospital. I can only explain what I did. I went to my house officer the day after Kent State and asked him if he felt my presence was necessary for the staff to care adequately for the patients. He said it wasn't, and I said in view of that I felt that these issues were more important for me to deal with. I made myself available to go in and help them at any time that they needed an extra hand. The people who did go on strike were careful to see that they didn't compromise their other responsibilities.

What have we done? Our projects are basically of three types: education, community action, and government action. With a strange kind of appropriateness we were given an office under the anatomy labs in Building E. People began working to organize a teach-in for that Friday, which was declared a day of mourning in respect for those killed and wounded at Kent State. We discussed issues related to repression, the war, and health care delivery. We began talking to workers in hospitals and learning a great deal from them about their situation and their concern for these issues. One committee gathered information and put together some excellent leaflets on Southeast Asia, repression at home, the effect of the war on health care, and strike activities.

An active group put out a great deal of information on the Black Panthers. They are collecting needed funds for the People's Free Health Center, have set up a library, and went to the trial of a Boston Panther, Big Bob Herd. He was acquitted, and his lawyer noted that the presence of so many concerned white people tended to dampen the judge's tendency to assist the prosecution in the case. They are forming a permanent trial watcher's group.

Many of us went to Washington to attend the demonstration at Mr. Nixon's doorstep and to talk with people in government. Two hundred people from the medical community chartered planes to fly to Washington to talk with congressmen and

senators about pending anti-war legislation.

Some of us got up even earlier than we usually would for rounds and gave out leaflets at factory doors and on street corners. I can personally report that one day one-third of the Cambridge Yellow Cab drivers were giving anti-war leaflets to their fares. Some people circulated petitions in support of the McGovern-Hatfield amendment, and some worked on Referendum 70, which is a petition drive to let the people of Massachusetts vote on the war in November. An information phone has been set up, which is equipped to provide complete information on voting records, current legislation, and means of contacting men in government.

In response to the Augusta and Jackson State murders, a group of black medical students here and their supporters held a meeting with Dean Ebert. He agreed to work with them on several demands, including the establishment of a community committee to decide when to bring armed force onto this campus, to work on providing better health care to black people, and to set aside an official day of mourning for the black people killed. During that day we had a teach-in that included a first-hand account of events in Augusta from Dr. I. E. Washington, a school principal who flew up to explain his disillusionment with the government he has worked for.

We have been learning, trying to teach others, reaching out to the community here, and trying to influence the government. I chose that order deliberately; it is the increasing order of difficulty. If we learn nothing else in medical school, it is that it is easier to learn than to teach. We have had some success reaching people in this area, and received a positive response from some people who six months ago did not feel very positively towards us. As for government response, unless you are fooled by the early morning walk of President Nixon, a man who ought to have trouble sleeping, then the facts speak for themselves. The government is not listening.

Obviously I have omitted one other thing we are doing — and that is talking with you. We are trying to explain our concern to people who may agree but are silent, or who may be unsure, or who perhaps violently disagree with us. In a sense we, all of us, are a constituency. Many of us who went to Washington were frustrated by the fact that men in government saw no reason to listen to us — we represented a few votes to them, nothing more. You do represent more. The more we as individuals do, the harder will it be for the government to ignore us. The more we as a group do, the harder will it be for the government to ignore us.

This is an upsetting time for me. I have been elated during the last month — as when a doctor who three months ago was supporting the war asked me how he could go about supporting the strike. But most of the time, I am afraid, I am overwhelmed with the horror that our inaction brings. The war grinds on, maiming and killing; warping us. Police beat and kill almost at will, while Congress solemnly continues to legislate away the liberties that our GI's are supposedly defending. We allow the Pentagon to rob us of good health and direct the funding of our universities towards death. More students are killed. More blacks are killed. That blood is on our hands and those chains are on our wrists until we struggle hard enough to remove them. The first rule of medicine is to do no harm — we violate it daily by inaction. Peter Marshall, late chaplain of the Senate, said: "If you don't stand for something, you'll fall for anything."

Let's stand!

Governance and the Administration

Robert H. Ebert, Dean

BECAUSE of the unique qualities of the university, it is difficult to devise the most appropriate kind of decision-making apparatus. On the one hand, the university must provide maximum personal freedom for the faculty and for the students, and on the other, it must provide an optimal intellectual discipline. There must be freedom to criticize, to dissent, to hold unpopular views, but there is a simultaneous need for intellectual rigor.

Universities were designed to foster the intellectual and professional abilities of the individual, whether he be student or faculty member. They were not designed to produce a particular product, unless one wished to call the student the product, and they were not designed to directly provide any service.

Any project undertaken by the university, which generally involves groups of people, has to evolve from the mutual interests of concerned faculty and students. There is no superior authority that can dictate or control action, whether in research, development, or community affairs. The university is among the most decentralized of human institutions.

Dr. Ebert

Although the university operates in quite a different fashion than a private corporation, or a government agency, it is often attacked because of the activities of a particular group of people associated with it; or it is criticized because it does not take an institutional stand on particular issues. Yet, the university does not exist as a separate, supreme organism; it is made up of a variety of interests, opinions, and people, no one of whom can speak for the whole body.

This decentralization in organization is repeated in the financing of universities and medical schools. Financing is categorized in the form of support for faculty, research projects, and the maintenance of the physical plant. It may come as a surprise that there is no free money that can be mobilized to start new projects. All the money is budgeted, even to the point of deficit. And only by attracting new money can a university or medical school begin new projects.

Whether the source of funds is public or private, and the university's ability to attract it for its purposes, depends significantly on the current interests of the public, as reflected in the appropriations of Congress. Witness the current cutback in research grants. What the medical school is ultimately able to accomplish — in biological research, applied research, education of more physicians or health care delivery — depends on what the public thinks is important and is willing to devote funds to support.

Another area of misunderstanding, with special reference to health care delivery, surrounds the question of whether a university or medical school should operate service programs. There is a significant difference between running an agency, such as a hospital, and being affiliated with an operating agency. As all of you are aware, the philosophy of the Harvard Medical School has been to affiliate with, rather than own and operate, institutions that deliver services. There is a good reason for this. Universities are not designed for managing large projects or dispensing specific services, and they are not, therefore, efficient in this role. What they can do, and do effectively, is to catalyze the development of projects. The university must, of course, be concerned about the community in which it lives; it can encourage the development of community projects; it can provide a variety of experts to help in their development; and finally, it can sponsor by affiliation, but these projects should have their own corporate identity.

This philosophy can be used to good advantage in the present situation by encouraging affiliation with broader groups of hospitals and community care institutions. University and teaching hospitals have become, in effect, specialty hospitals that provide superb opportunities for training postgraduate physicians, but they do not always provide the total environment necessary for teaching medical students. There is a need today for affiliations and associations with hospitals and institutions that deliver much more in the way of primary care. To move in this direction will not be easy; the whole approach may give rise to certain ambiguities, to duplication of effort, and to internal friction. But it is, we think, a more productive mode of operation than one that is self-contained and dependent upon a university-owned and operated hospital.

This diffusion of responsibility and initiative, this flexibility in structure and operations that characterize the university community, make it apparent that we cannot develop a legislative process for the whole school. If we are to continue to have the type of institution that innovates, we must protect the rights of individual initiative on the part of the faculty and the students. Perhaps the most important quality of the university, and one of the reasons that it is in the midst of today's unrest, is that it is, and should be, the home of dissent; it is the home of criticism; it is the place to examine critically our society and to make suggestions for change. This is a quality that cannot be legislated.

Dr. Ebert greets an alumnus; Dr. Taylor answers questions.

HARVARD MEDICAL SCHOOL ANNOUNCES

The William O. Moseley, Jr.

Travelling Fellowships

THE BEQUEST OF JULIA M. MOSELEY MAKES AVAILABLE FELLOWSHIP FUNDS FOR GRADUATES OF THE HARVARD MEDICAL SCHOOL FOR POSTDOCTORAL STUDY IN EUROPE.

The Committee on Fellowships in the Medical School has voted that the amounts awarded for stipend and travelling expenses will be determined by the specific needs of the individual.

In considering candidates for the Moseley Travelling Fellowships, the Committee will give preference to those Harvard Medical School graduates who have—

1. **Already demonstrated their ability to make original contributions to knowledge.**
2. **Planned a program of study which in the Committee's opinion will contribute significantly to their development as teachers and scholars.**
3. **Clearly plan to devote themselves to careers in academic medicine and the medical sciences.**

Individuals who have already attained Faculty rank at Harvard or elsewhere will not ordinarily be considered eligible for these awards.

There is no specific due date for the receipt of applications or for the beginning date of Awards except that the Committee requests that applications not be submitted more than 18 months in advance of the requested beginning date. The Committee will meet once a year in January to review all applications on file. Applicants will be notified of the decision of the Committee by January 31. The Committee may request candidates to present themselves for personal interviews.

Application forms may be obtained from, and completed applications should be returned to:

Secretary, Committee on Fellowships in the Medical School
Harvard Medical School
25 Shattuck Street, Boston, Massachusetts 02115

Harvard Medical School and Its Relation to National Problems

David J. Greenblatt '70
Intern in Medicine
Montefiore Hospital
and Medical Center

In no way do I represent the views of my class or those of the student body. I support the efforts of the United States to maintain its own security and the security of its allies in Southeast Asia, Cambodia, or anywhere else the Administration feels is necessary. I deplore the efforts of student groups to disrupt the actions of the United States. With respect to my own position on the role of the medical profession in national affairs, I am, at this point, thinking about the draft. I am willing to do whatever the Nation asks of me in the service of my country. There are many boys younger than I dying in Vietnam. Some people will say they are dying needlessly because of American imperialism. I believe they are dying for the cause of freedom, but no matter what we think, they continue to die and someone must take care of them. If I am called upon, I would be happy to do so.

Lloyd Axelrod '67
Research Fellow in Medicine
Peter Bent Brigham Hospital

It has been said that it is not the role of the institution to take a stand on national problems. The university is a broad umbrella of many points of view. It does not represent dogma. But institutional neutrality is a myth, and there is another myth that the university is unaffected by what happens in its environment. The university is in a very real sense a victim of what is happening in the world around it. When we expose the myth, we are obligated to say that the university should not be passive in its own destruction. There is a danger that we will have a situation like the one in Latin America where the universities are so political that their function is impaired. This

is a risk, but there is the greater risk of inaction. Inaction also impairs the function of a university.

One of the problems today is that people often think that we who are protesting, who are asking institutions to take a stand, are in some way unaware of the risks. We are aware of the risks on both sides, and this is the crucial issue. Many people believe that we do not support our country and would not provide medical care for our fellow Americans who are dying in Vietnam. We are all concerned about our country and such rhetoric is inappropriate. The question is, what is the proper course for the country? Some of us feel the most appropriate course is to prevent these people from being wounded. Helping to heal a stump is not as effective as preventing the amputation.

The various roles of the state is the issue, but when we say this we are accused of talking about some kind of communist monologue. There are two analogies here. Lessons tend to be overlearned; the lesson of Munich was overlearned, and the lesson of the totalitarian monolithic communist state was overlearned. Both of these have valid truths but one must not be blinded to the other issues involved.

When action is compared to inaction, when the risks of action are compared to the risks of inaction, then the need for action becomes clear.

Joseph B. Alpers
Assistant Professor
of Biological Chemistry
Harvard Medical School

A medical school has functions that are appropriate for all times; namely the education of physicians, and the production of physicians to provide adequate and excellent medical care in this country. Other functions that are appropriate at all times are the superintending and delivery of this care, at least in a model sense, and the extension and development of the scientific basis of medicine.

In these times of social upheaval, there are other impingements upon a medical school. When there are serious racial divisions in our country and too few black doctors, we must be concerned with the production of an adequate number of black physicians; we must tailor our admissions program to this need; and beyond that, we must be prepared to set up special programs if needed.

There are other factors that impinge on a medical school particularly when the basis of the medical school in many of its economic aspects is tied so closely to national funding. Disasters abroad cause curtailment of domestic programs, a cut back of our own research grants, and in a tangential way, the dependence on federal funding makes us think twice before participating in political action that might reflect on the university as a tax exempt organization. The emphasis today is on results, on applied research, and on immediate solutions to problems, so that the limited funds that are available are diverted from what might be considered the more basic problems to programs that are more easily visible as pertaining to social

relevance. This can be an insidious, and in the long run, a very wasteful thing, because without the kind of basic reseach that sets the tone for the entire institution in both its applied and basic departments, standards will undoubtedly fall. Moreover, without the kind of basic research for which funds are now being cut due to other national priorities, there will soon be nothing to apply if one is insisting on applied research.

THOMAS H. WILSON
Professor and Head of the
Department of Physiology
Harvard Medical School

The federal government tells us we must produce more physicians. Numbers vary, but many would like us to double class size. It is absolutely essential that we increase the number of graduating physicians for the future welfare of this country.

In the face of the government demand for more physicians, what have they done to help us train more physicians? They have not provided us with a single penny or scholarship aid for medical students. The loan program, which was a restrictive one, has actually been cut for the medical students. Who will teach our medical students? They will be taught by the young individuals who are studying for their Ph.D.'s in the basic medical sciences, and those young M.D.'s who are being trained in research and teaching methods. Who has supported these people in the past? The government has been generous and supported such individuals knowing that they had to be supported for the future of medical education in the United States. Last year the Bureau of the Budget advised HEW that this was one place where funds could legitimately be cut. And it was only at the price of an attempted resignation of one of the senior officers that prevented a complete loss of training funds for this year. Next year we are guaranteed that there will be no training programs. The training grants promised us by all the high ranking officials of the USPHS will be reduced to zero.

Let me tell you the cost of educating a Ph.D. Why? What difference? Because what is proposed by the Bureau of the Budget is that those individuals who were previously supported by training grants from the USPHS now can take out loans. What will the loan be? Tuition is $2600; living expenses for the first year are $2400. We have 100 Ph.D. students in these buildings studying to be teachers of the future physicians of this country. Each of these students will graduate with a loan indebtedness to the federal government of $25,000. It takes no great imagination to realize that the number of years needed to repay this loan will discourage many individuals. There is no question in my mind that this $25,000 indebtedness will greatly reduce the number of individuals who will train for the Ph.D. degree in the basic medical sciences. This is the administration's answer to the training of more physicians for the future. The two are irreconcilable.

We do not have the necessary support because funds are diverted to other activities. It is obvious that medical education and the medical care of the future are being seriously impaired because of our activities in the Far East.

CALVIN H. PLIMPTON '43A
President
Amherst College

The rising degree of affluence and the increase of leisure time in our society has caused students, who previously concentrated on getting a job or another television set, to devote their attention to a study of society itself. What they have seen indicates the wide gap between what is referred to as the American dream and the American reality. Students experience so acutely that many of them seriously believe they have discovered poverty, injustice, and racism as though it had never existed before.

Universities have been getting a major share of the criticism because we are handy, we are fragile, and we have never been particularly quick to change or responsive to society. It is very difficult for an institution to commit itself on specific issues. I think it is more; it is a real mistake. Harvard Medical School can be against death, disease, and poverty in general terms. It can fervently hope to improve the delivery of medical care. But when an institution gets into political or economic issues, there are three dangers that must not be underestimated.

Our business at medical school is education. Like other institutions

Professor Jonathan Beckwith explains Panther literature.

there is an upper limit to our energies. There is only so much we can do as an institution. If we move as an institution into political or economic spheres, there is the danger that we may dilute our educational effort. The second danger is that if we move into the political arena, we can anticipate that the politicians will move into our arena. And our own laundry is not terribly clean. The third danger is that if we adopt an institutional position on a political issue such as Vietnam, this position may act as a deterrent to that freedom of inquiry that is so vital to education. What we think as individuals should be kept separate from what we think as institutions. We have enough problems in our own backyard and we must concentrate on these.

David D. Potter
Professor of Neurobiology
Harvard Medical School

A committee has been appointed at Harvard to investigate what the size of our classes should be and how our training effort should be distributed. You cannot deal with these questions without getting into the questions of whom one should train and for what purpose.

Speaking entirely personally, I believe that in the last decade we have behaved more or less passively. The problems we have investigated have borne little relation to the needs of the country or the world. They have borne more relation to what we found intellectually challenging. At some point in the future, these will unquestionably aid human welfare, but faculties have not distinguished themselves either for their wisdom or their humanity in the type of training they have offered or the projects they have pursued.

Thomas B. MacKenzie '70
Intern in Medicine
University of California Hospitals

As citizens, we all have a point of view about national problems, but I think the critical question is what should our point of view be as doctors? Does the fact that we are physicians give us any special responsibilities in terms of speaking on affairs of international conflict? I believe it does.

Recently, in one of the prominent liberal establishment magazines I read an article written by a physician who argued that the role of the physician is really not as social innovator, but should be confined to the individual doctor-patient relationship. He argued against the idea that the physician should oversee all phases of human health. The problem is how broadly should the phrase human health be interpreted. I think we could make a case for viewing war, poverty, and ghetto living as medical problems.

Dr. Mackenzie was the final scheduled speaker on the panel. The following remarks were made by people in the audience who are identified where possible.

Joseph M. Looney '20
West Roxbury, Massachusetts

There are many M.D.'s working in laboratories on problems that are not particularly related or relevant to the care of patients. If the federal government cuts back funds for these people, perhaps they will go out and practice medicine. This would increase the number of doctors available to practice medicine.

Joel W. Adelson
Research Fellow in Biological Chemistry
Harvard Medical School

We have heard several people talk about concentration on education, concentration on our daily business, concentration on continuing as we have, and this seems to be a rather popular viewpoint in the audience. I am disturbed that at this point in the crisis, people could think of nothing more pertinent to say than our own linen is not exactly clean; that we had better watch out what happens if we start letting the government into our back yards; that we better continue to focus right in front of our noses on what we know traditionally to be our business. You are ignoring what is clearly one of the greatest crises to confront America in hundreds of years. It is not a little academic crisis about whether the medical students are going to learn more or less in two or three weeks by going out on strike or by participating in peace activities. The dedication to the peace movement and the attempt to bring universities into the peace movement is something that arises in the gut of every young person, and many faculty as well. We have our eyes and ears open and see the national disgrace that is being perpetrated, and we are not going to be turned aside by a viewpoint that says this is none of your business.

I am sad that we can sit here in the sun and imply that this whole thing would go away if only we could find a way to persuade the students to get serious. I would suggest to you that the students have never been so serious. Perhaps getting serious ought to begin among the alumni.

David J. Greenblatt '70

As you have just heard, there is deep concern among people my age about the allocation of resources by the federal government. The implication is that were the war in Vietnam to end tomorrow, suddenly the 35 billion dollars or whatever would suddenly be redirected toward those problems that require these funds. I would agree that there are some unfortunate consequences of the present allocation of resources. There is legitimate research that is losing funding, but I would also maintain that the attempts of the administration to adjust the way resources are being used is not all bad. One need only pick up a journal that is not in the mainstream to realize that there is much research that does not deserve to be funded. There has been talk today of educating more doctors. We graduate some 10,000

physicians a year and it has been suggested that we need 20,000 a year. What we need is not so much more doctors, as good doctors, and I would question whether doubling the enrollment of our medical schools will indeed produce the number of doctors needed to care for patients.

David S. Fischer '55
Orange, Connecticut

I think many of us have perhaps felt somewhat resentful of the tacit assumption by some of our younger colleagues that we are all in favor of killing, and that we characteristically deliver poor medical care, and that we are unconcerned. Just because we do not have the same fervent enthusiasm that some of our younger colleagues have now does not necessarily mean that we did not have that enthusiasm a few years ago. Part of the problem in universities has been that we have not directed our efforts to those things we are most competent to do. I have no particular competence in deciding what military tactics should be; I have been trained to practice medicine.

We must direct ourselves to getting the powers that be in the government to concentrate on those things that should be done. It was said today that we have to have more money for research because it is the people who do research who teach. This is something like buying a pig in a poke. We ought to pay researchers to do research; and pay teachers to teach. We ought to promote teachers who teach, and researchers who do research. But we should not mix the two because there is no particular reason why one who does good research is going to be a good teacher or why a good teacher is going to do good research. The dichotomy of trying to get the government to pay more for research in order to produce more teachers is deceptive. As physicians, and as an organization, we must bring these things to the attention of those agencies that control funding.

Harvard Medical School's Role in Community Affairs

Leonard W. Cronkhite, Jr. '50
Lecturer on Preventive Medicine, HMS
General Director, The Children's Hospital

Some years ago the ills of the metropolitan core cities surfaced; the diagnosis was that they were sick. A series of commissions, bureaus, and bureaucracies was established to dissect the total problem into its component parts. These involved housing, public schools, health, jobs, job training, sanitation, recreation, historical sites, space, clear air, and a whole litany of diagnoses with the patient being simultaneously afflicted by all of them. Then funding appeared on the scene and solved part of the problem. No priorities were set, and there was no overall administrative vehicle by which priorities might be set. The net result, after almost a decade of this diagnosis and the expenditure of millions of dollars, is minimal.

Little has happened to improve the lot of the citizen who lives in the core city. Everyone passes the ball back and forth between local government, federal government, and various private enterprises. In one instance the citizens themselves took part in the reorganization which, in my opinion, seemed like a fourth branch of the government. This is the local community action group, where citizens divide themselves into more or less homogeneous areas, elect governing officials, establish their own internal priorities, and then attack the various power structures to meet their needs.

At the same time the mayors of many large cities recognized that this activity was a fragmenting disease pattern that attempted to bring government down to the local subcommunity level with miniature city halls. Simultaneously the concept of model cities came into view. There would be a singular administrative head to take all the problems of ten percent of almost a hundred cities and see what could be done with them if funding were provided. So there were various efforts at various levels to clear these many roads of the inner city.

As you have heard this morning, and as you will probably hear for the next few years, young people take a global view of all these ills. They are convinced that you cannot solve one without solving them all. We have had many young health workers go into the local community and recognize the legitimate interweaving of bad housing and poverty, bad health and poor sanitation, no jobs and the like. They are dismayed by the overwhelming intensity of the problem; a few of them who are not thick skinned enough finally decide that there is no hope, and that there is no sense in giving good medical care because it will not make a difference in the structure. This is a rationality to cop out.

At Harvard, as with all other educational institutions, the next problem becomes the action following universal concern. As Dean Ebert pointed out this morning, one has to make a fundamental choice between operating a program or catalyzing a program designed so someone else can operate it, and then being a severe critic of it. My own feeling is that HMS has not had the internal competence or financial backing to mount large scale operational programs under its own banner. It does have, however, the operational competence to stockpile its demonstrations, to begin a data base so that subsequent evaluation to answer the critical question, "have you done any good?" can be answered in such a way that we can accept the answer. If, therefore, the medical school is not to be the direct operator, who else should?

In the last five years I have served on multiple task forces in Washing-

ton. There has been general dismay about the capacity of university teaching hospitals to mount large scale operational programs, and about the effectiveness and general reservoir of talent appearing in the municipal and state health departments. Within the last few months this dismay at the present establishment and their power structure has become so high that the notion of a new kind of organization is now being heard in the Senate.

The notion has firmly taken hold that a health maintenance organization must be an industry. It must be a union, a hospital, a group of physicians, a separate nonprofit entity, or conceivably a medical school. It could be a wide variety of organizational structures that would promise to accept their responsibility for the comprehensive health care of a designated target population. According to local conditions all over the country I think we will see that this goes through. We will see a wide variety of organizational patterns that are different from the ones you and I are used to living with, so far unsuccessful in raising results. Whether or not it will work any better than our present pattern I am not prepared to predict, except to say that it really cannot be much worse. Some of us here have taken on the design of a health maintenance organization; we are learning as we go. We realize it must be of a large enough size if it is to make any fundamental impact on the entire population. It has tremendous organizational and logistic problems. It has manpower problems. There are many unknowns, but we will never know unless we try. Those are two thirds of my remarks.

I would like to switch back to the medical school and ask what else should the medical school do in relation to the community? There are two things that have bothered me for some time. One is to honestly address the question: Are the medical school students today fairly representative of the population they are preparing to serve? My own personal feeling is that they are not.

The second question is: Are the value systems, which are instilled in the medical students while they are in school, so unidirectional that success is equated with worship at the altar of science and failure is sometimes equated with taking care of sick individuals? We have talked at various national levels about this and some believe two kinds of medical schools may evolve — one to train doctors who are dedicated to direct service, and the other to train scientists and teachers, conceptual and intellectual leaders. Though many hope this will not happen, I predict it will. Each individual medical school will make possible at least two creative pathways, different in content, but equal in academic recognition. This will be the vehicle by which those who are dedicated to serve the poor and the sick are no longer considered intellectually soft, second-rate physicians, who have no place in the community of scholars.

FRANCIS D. MOORE '39
Moseley Professor of Surgery, HMS
Surgeon-in-Chief, Peter Bent Brigham Hospital

Last April students occupied University Hall; one student demand was that Harvard should not expand into the community. The spinoff from this was very rapid; President Pusey stated there was no such plan. This was said to be erroneous because the hospitals closely associated with Harvard were planning to expand into the community. This led to a premature and very clear polarization; in fact, the day after the occupation, we were already in trouble. The Dean and the President then said that 1100 housing units would be built here before any hospital expansion could occur. Many people felt that university high-rise apartments in this immediate vicinity would not be best for the community. And that set off many months of working together, working with many students to try and improve the situation in the community. There can be absolutely no question that the students' active protesting caught the older generation out to lunch. We did not know what was going on in the community; those of us on the hospital staff were completely unaware of the purchasing and evictions that were going on next door. When I became aware of this situation last November, I realized we were dealing with something much more ominous and difficult to resolve.

The document I have given to you is fairly characteristic. The text in rough draft is by Dr. James Shapiro, a bacterial geneticist. Information, ideas, and criticism were contributed by four students; one or two of them are here today. The document begins with a quote from President Pusey. "Our purpose is just to invest in places that are selfishly good for Harvard; we do not use our money for social purposes." Dr. Pusey made this statement in reference to a university portfolio investment policy. He may well wish he had never said it. The statement, taken out of context and put here in relation to the hospital, medical school, and the efforts of people to help other people, represents the hard core business that we are up against. Now the students campaigning this are no neophytes. Our first and second-year students are bright; they are concerned with the welfare of people. Many of them, coming straight from college, have a great deal of experience in political activism. I feel

we are inexpert in dealing with their activism.

I feel helpless about several tactics commonly used by the activists. The first is to select business statistics or numbers, data taken completely out of context, and then to pose rhetorical questions. For example, the other night at a meeting that should have been friendly, we found the chairman, instead of impartial, a hard advocate against the hospitals and the school. We were asked "Why were you planning for 135,000 rather than 250,000 outpatient visits?" Well, this is like being asked, when are you going to stop beating your wife? As a matter of fact, the number of outpatient visits that we can afford to plan for has not been settled; it is still being dealt with by people of good will who are working in this area. It is very difficult to deal with large groups of people when numbers like this are thrust upon you and you are requested to give a simple yes or no answer. Second, a favorite tactic is to ask for the final plan of the hospital. The other night, for instance, one of the students said he had not yet seen the final plan. He then expressed irritation that the plan was not available when actually the amount of money we might have and the size of the institution are not yet clear, let alone detailed. The third tactic is simply that this whole struggle has made the location of the hospital and money raising terribly difficult. Those who oppose it make a public statement that because money raising is difficult and the site is unsettled, the project must be worthless. Actually, the project is worthless for the two reasons for which the opposition is partly responsible. Fourth, and most disturbing, the hospitals are forced into a defensive position on the care of the local community, and the new Affiliated Hospitals Center will share the care of its community, which is the Roslindale, Roxbury, Mattapan, Dorchester area, with at least three other hospitals, Boston City Hospital, Beth Israel Hospital, Children's Hospital, not to mention the Women's which, of course, is part of our association. Our repeated public declaration is to draw attention away from the fact that these hospitals, if they are doing their job, also serve the student, the nation, and the future in the form of research. It happens that two of the three hospitals concerned are already deeply involved and committed in community care. They wish to make this much more comprehensive, make it a primary care center instead of the old-fashioned outpatient department, with better community representation on boards of trustees and all levels. If they can succeed in doing this, which they wish to do, they will be serving the local community better than they ever have, more expensively, and more acceptably. They will still maintain our ideal to serve other communities as well.

With this as background we find ourselves as doctors, physicians, and lay people searching back and forth among the student demands and the demanding students, trying to differentiate between those who want to help and those few who are deeply committed to the stated objectives of destroying this future hospital for Harvard.

Edmund L. Carey, Jr. '70
Intern in Medicine
University of Pennsylvania
Affiliated Hospitals

Last night I was reading from the collected works of George Waldo, which have bearing on many of our considerations. One of the pieces Waldo wrote in 1929 was an article titled "How the Poor Die." It recounted his stay in a sanatorium, rather a public hospital of that character, in 1929. As you know, George Waldo had tuberculosis; he eventually died of it in 1950. He described the way patients were treated in the public ward. This was indigenous to France, but reading the description of the way patients were taken care of, and their attitudes towards being treated, I found little difference between the treatment these patients received in public hospitals in 1929, and the way many of our patients on the wards are treated in the Harvard teaching hospitals.

We are upset; medical students are upset. I have been in the hospital wards for two years, not a very long time, but I recall when I started on my first day of physical diagnosis, Dr. Cass, who was running the course at that time, said, "Keep your eyes open and look around and let us know if you see things that you think are wrong, because we have been around for a long time and we get used to things. Things that do not strike us as being abnormal, or wrong, or evil may well be that way." I think that is what a lot of us are trying to do.

Why are we upset? In the midst of the wealth of medical resources in Boston, we see millions of dollars being spent for research, for clinical research centers, for ultra-teaching and research facilities. We also see communities like Roxbury, the South End, Dorchester, South Boston, and Jamaica Plain, which have one common and distinguishing feature: They have many blacks. That entire segment of the community receives atrocious medical care, and there is no reason for it. It has been going on for a long time and people have been accepting it. We are told we have to do a lot of study and decide how to solve this extremely difficult problem, the delivery of medical care. I am not saying that it is not an extremely difficult problem, but it has been studied for a very long time. A lot of money has gone into the study of this problem; a lot of papers have been written. But there has been no single attempt by the medical staff in Boston, or in this country, to solve the problem of making sure that the people in the 1970's receive adequate medical care, or at least receive medical care that is superior to that given French tuberculosis patients in 1929.

I cannot answer for the document Dr. Moore has. Some of you may find it an overstatement. If overstatements occur, and I am not apologizing for this particular document, they occur because of the level of

emotional involvement. The reason students are upset and the reason they direct their public reaction towards hospitals like the PBBH is as follows: The Brigham is located in direct geographic proximity to a number of areas in which medically deprived people live, specifically, the section of the Roxbury-Jamaica Plain area called Mission Hill. It is true, despite some claims, that it is a community hospital and serves the population surrounding it; it is nonetheless true that twice as many people from the Jamaica Plain area go to Boston City Hospital for their treatment as go to the Brigham. Now why this is I do not know; this is a system that has been set up for a long time. Why is it that facilities for ward patients from the surrounding community are so different in the Brigham and in other hospitals around the state from facilities for private patients? This is an odd system, a system that most of the alumni grew up with. We did not; we were told to look around and see what is wrong, and see what could be done about it.

Medical students are sometimes accused of making unreal claims on the medical school. The medical school's response is, as Dr. Cronkhite said before, that we do not have the operational capacity or the funds to deal with a problem of this magnitude. I think that most people realize there is at least partial validity to this claim. However, HMS has influence and organizational ability, particularly for getting hospitals together. We are currently providing medical care for overlapping segments of the city; there must be 25 or 30 community health programs that are based in our various teaching hospitals. And yet there is very little communication among them. I think HMS has the existing organizational capacity to get these people together.

I have a final point and it is a point of urgency. Medical students and students in general are always accused of saying "Action now, we've got to get things done now." This may sound anti-intellectual, but many different approaches have been studied over the years to deliver medical care to the poor. None of them has been tried on a large scale. It is time we abandoned our intellectual bias that things have to be demonstrated on a small scale. It is time to employ a therapeutic trial and do something to unite these agencies to try and deliver medical care to the people in the city who have been deprived of it for years. That right belongs to them.

WILLIAM V. MCDERMOTT, JR. '42
Cheever Professor of Surgery, HMS
Head of the Department of Surgery, Boston City Hospital

I can talk to you with considerable warmth, impatience, and with some degree of bitterness about medical care systems in this country. Boston City Hospital is perhaps one of the most typical municipal hospitals in the country in terms of medical care given to its patients. The professional care may be good intellectually, the self may be put into the care, but the environment, conditions, organization, administration, and the money available, make for indecent and undignified medical care. Therefore, in theory, I would be in a superb position to attack Boston City Hospital and those like it. As a matter of fact I have; my attack has been directed against the administration, not of the university, but of society.

The situation we see at hospitals such as the BCH is, in my opinion, the responsibility of society, of each and every one of us as citizens, and of our elected representatives in state and federal governments. This is where the burden of health care should fall. What is the role of the university in relation to the city?

I understand far too well the impatience, bitterness, and frustrations of students when they see our present systems of medical care. I can also understand how they would strike out at what is near to them, the university or medical school. This does not lend a constructive concept as to how HMS can face social problems. As you will frequently hear someone say, "Harvard has a billion dollars in endowment. Why not put this into medical services? Harvard could sell not only all its GM stock but all its other stocks and resources and pour it into the medical care system." I think it is clear what would happen in five years; Harvard would no longer be in existence and medical care would relapse rapidly to where it was. From the point of view of financial resources, the university cannot do this.

The university provides a national resource even though it exists geographically in a particular community. It cannot take all its resources and face a critical crisis in our medical care system. Unless, of course, you want to end up with no university at the end of this decade. The deficit in our medical care system demands that something be done by society. Also, it is important to recognize our universities as a national resource; we should not attempt to gradually pour water out of a can in our efforts to solve a number of social problems. This does not mean that the medical school cannot take a leadership role in providing pilot studies, plans, and ideas such as Dr. Cronkhite and Dr. Knowles have done, such as the Affiliated Hospitals Center has been trying to propose, or such as those of us at BCH have been trying to present to society, for correction of patient care. The plans are there; it is up to you and me, to all citizens, to listen to some of these plans and to do our best to implement them.

The way to implement them is to arouse the government to face this problem. The government is the source of funds required in huge amounts to establish a decent system of medical care. This funding comes from all of us as citizens; ultimately it is channeled through the government. I am not defensive about either the BCH or HMS. I recognize the tremendous inadequacies that we are struggling with at a municipal

hospital, but I also recognize the distinct limitations of universities and university hospitals in correcting these abuses. I propose to you that our energies should flow from the university towards arousing the citizens of the country to correct these abuses rather than to attack the university which is ultimately the source of ideas leading to the appropriate solution of the problem.

Charles E. Lewis '53
Professor of Social Medicine, HMS
Assistant Director, Center for Community Health and Medical Care

About five years ago those of us in the community of social medicine were suddenly faced with a power wave of activists. Two or three oddballs rolled along in the year who were interested in the community health care problem; we thought they had something wrong with them. In 1965, with the Student Health Organization, the rhetoric began and has continued ever since. It came as a distinct shock to all of us when what we considered to be the new brotherhood kicked us in the groin, went right past us, and considered us to be the biggest hypocrites in the medical school because we had the tools to do something about the community and we did not apply them. We were too interested in study, teaching, and trying to develop some confidence. This raised an issue in our minds, and last year we completed a study that helped solve the problems of teaching some of the things we are talking about. Most of the Harvard medical students and medical students anywhere are brought to us in subsections: I hate to categorize people but I would say that most medical students are (1) pragmatic; (2) conceptually interested in what needs to be done and planned; and (3) interested in action.

While the content of community medicine is the same for the three groups, the process is quite different. Those who are interested in pragmatism want to know whom to call to get what done; they are not particularly fascinated with the theories of economics or social sciences. Those who are interested in concepts do not want the pragmatic approach; they want to know the literature and its scientific validity. The activists want none of it; they want to discover the wheel themselves.

Last year the first-year students here were given a list of telephone numbers for people in Roxbury and were told to go and find them. These students defined themselves as a task force, and in a period of time discovered what I could have told them in three hours of didactic lecture. But having discovered it, they believed it. If I had told them, they would have rejected the whole thing!

Dr. Lewis was the final scheduled speaker on the panel. The following remarks were made by people in the audience who are identified where possible.

A Doctor from New Haven

The physician has an illusion about his importance. It seems to me that the difficulties that Dr. Moore brought out were all in part due to that illusion. We have the illusion, which is fostered by the community as well as by ourselves, that we can in fact solve the medical and health care problems of our country. We have enough trouble solving simple medical care problems; the health problem, such as Dr. Cronkhite has pointed out, we cannot possibly solve. It seems to me that we ought to recognize this illusion for what it is and begin dealing with it. Until we do, until we realistically discover what we can and cannot do, we are going to be happy scapegoats.

William J. Baker '42
Laconia Clinic
Laconia, New Hampshire

We must define communities. There is a ghetto in Laconia, New Hampshire, but it is a small ghetto and the people there are no different from people anywhere. I would suggest to Dr. Carey that if he wants to find out what the practice of medicine is, he might well apprentice himself to people like myself and see what it is to treat patients rather than disease.

The second point I would like to make is that I have to agree with what Dr. Taylor and Dean Ebert said this morning. Medical schools have no business surveying medical care. No one at HMS taught me how to practice the art of medicine. Maybe you cannot do this in a medical school. Maybe you do it only as a part of seeing people who are sick.

The Inter-relationship of Administration and Student Body

Thomas H. Hunter '40
Vice Chancellor for Medical Affairs
University of Virginia
Medical School

As chairman, I would like to discuss a piece called *Protest, Past and Present*, by J. Brunofsky, senior biologist at the Salk Institute. He is a Polish-British Jew, now working in this country as a biological philosopher and scientist, who looks at us from the outside. He has certain perspectives on the scene that I think are interesting. He talks about protest and reminds that had it not been for political protesters like Benjamin Franklin, Thomas Jefferson, Voltaire, and a few others, we would not be exactly where we are. He also reminds us that you would not be what you are, and this is going to make me seem like a religious fanatic, if Christ or Luther had submitted to the religious authority of their elders. It is a sobering lesson in history that millions of people who dislike the contemporary forms of protest still call themselves Protestants. Brunofsky goes on to say that the generation gap is a moral chasm across which the young stare at their elders in distrust, convinced that the values that make for success are fake. Evidently the first area of suspicion is public life, and there the undeclared war in Vietnam has had a disastrous impact. Then he discusses the reactionaries from California -— the people who are really writing the hate letters to the columns about what the students are doing in the universities. He says, ". . . and yet exactly here the correspondence columns are filled with such hatred against the young, such hysterical fear of change, that one cannot imagine how the writers picture a university. Do they expect education to run backwards? Do they think there can be progress without originality? Originality without dissent? Or would they really like to burn the heretics?"

Mr. Kim J. Masters '72
Chairman,
Student-Faculty Committee,
HMS

The Student-Faculty Committee was set up in the late 1940's to administer affairs of Vanderbilt Hall. In 1963 the constitution was re-written with the following preamble:

> For the purposes of increasing communications between the students, the faculty, and the administration of HMS, of overseeing and directing the student use of Vanderbilt Hall, and of improving the general environment both in and out of classes, this association has been formed and this constitution developed.

Despite these laudable intentions, the SFC has spent most of its time arguing about bills and parietals.

Last year Dean Ebert and some students on the committee decided to make it a major political force in the medical area. Its function would be to present the desires of students and faculty to the administration and to the appropriate faculty committees. The committee was reorganized. Instead of having four junior faculty members and ten students, the SFC now consists of ten faculty members, most with senior rank, who represent clinical services, basic sciences, and the dental school. It has eleven students who are elected representatives, and one alumnus from time to time. Supposedly the committee gains effectiveness and respectability as a kind of bargaining power between faculty and students. The students can be divided into two broad groups; one, the vast majority who are apathetic; and two, the small minority who are activists. Our task is to rouse the apathetic to come to the SFC meetings and participate in discussions. It is also our task to try to get the activists to let us help them plead their causes before the faculty and administration. As for the faculty, it is the committee's job to make itself known and respected among them. Clearly the challenges are enormous.

Here is the record of what we tried to accomplish this year. At the outset the committee consisted of four subcommittees whose job was to bring issues before the full committee. The four areas of concern were student affairs, community affairs, curriculum, and admissions. On each subcommittee was at least one student member. Anyone else in the medical area who wished to join was invited to do so. Through the subcommittees, the full committee was able to take the following actions:

> In the area of student affairs, we initiated some moderately successful student-faculty teas, mostly attended by first-year students. We also asked Dr. Gardella to write policies for the promotions board. Finally, we discussed the joint Harvard-MIT program.
>
> In the area of community affairs, we had a full-scale debate before the committee about the Affiliated Hospital Center's treatment of the people on Fenwood Road. Some of you may have read about this in *NEJM*. We have also tried to organize a committee to review the role of dental students in the medical area. To date, we have had no report. We managed to get students on the university advisory committee on community affairs. I think this will help us learn how Harvard interacts with the community that surrounds it.
>
> In the area of curriculum, we set up a committee to study teaching methods, and we may experiment with computers. We helped the students plan elective courses, and we have been trying to get better feedback to them on examination performance.
>
> In the area of admissions, we have constituted a task force of students and faculty, some of

whom were past members of the admission committee, to produce an overview on how the committee operates, and how it might better operate. This report is still before the committee.

In the area of governance, not a constituted task force, but a problem that landed in our laps, we worked with Drs. Blout and McDermott to formulate plans for a medical school committee on governance. SFC was asked to present to the faculty a document on rights and responsibilities. We were asked to assume the judicial function of administering discipline to students who violated these rights and responsibilities. The committee also asked to be an advisor to Dean Ebert in the event of a confrontation in the medical area. The result of these initiatives was the document on rights and responsibilities, which attempted to equate the administration's lack of response to needed change, with student violations of traditionally accepted freedoms. The faculty, however chose not to accept this document, but it did give us the power to make recommendations to the faculty about student disciplinary affairs.

The committee asked for a voice in commenting about teaching ability of tenure and non-tenure faculty. We recently asked Dean Ebert to explore the possibility of giving students a week off at election time to carry out whatever political activities they felt necessary. This is being discussed. The committee was asked to participate in a university-wide planning to support political actions to bring peace to Southeast Asia. Instead of taking political action, we decided to set up an office in the medical area to inform those interested about what other people are doing with regard to the peace effort. The committee is also working with women medical students to study the possibility of appointing a woman dean, advisor, etc.

What has the SFC accomplished in gaining support of students and faculty? For the students, the apathetic become excited only periodically; their interest is brief. The committee does not work fast and legislative change takes a long time. For the activists, the committee is too moderate, too powerless. For example, the committee played no role in initiating political discussions about Cambodia. Since the committee derives power from the officers of the faculty, and the interests of the activists often run counter to the interests of the faculty, activists tend to ignore the committee. There may be some virtue in this, however, because if the committee did have more legislative power, perhaps it would fall into the hands of non-representative groups of students. And in that event, the committee would lose its usefulness. As for the faculty, many are aware of the existence of the committee now; as for how much respect the committee can command, I really do not know. If this respect bases itself upon the ability of the committee to speak effectively and with the support of all students, then I suspect the committee does not have that kind of respect.

The main reason we should have student government is that students can make significant contributions to the medical area community, and can help to provide a formal channel for making these contributions possible. If we succeed in part in this goal, then I believe the committee's efforts will have been worthwhile. I do not know how much progress the SFC is likely to make in the future. Much depends on how its character has changed by the report of the committee on medical area governance. Until that report is issued, much depends on the support the committee receives from the administration and, I might also add, from the Alumni.

Dr. Cheever and Mr. Masters discuss the SFC.

ELKAN R. BLOUT
Edward S. Harkness Professor of Biological Chemistry, HMS

Students and the problem of participation were brought to the front in April 1969 with the now famous University Hall bust. As a result of that the governing boards of Harvard asked Mr. Pusey to set up a university-wide committee on governance with two faculty and one student representative from each of the nine faculties. It is a large committee, running between 35 and 40 members. We have met at least once a week since October 1969. Ob-

viously any committee of 40 members cannot do very much as a group so we broke into three subcommittees. One of these is concerned with what one might almost call the cosmic question: "What is the future of the university?" Another subcommittee is concerned with the administrative structure of Harvard University. Is the office of the governor being properly attended? Is the council of deans effective? What changes in the office of the administrative vice president or what reviews of their activities are proper at this time? The third subcommittee is concerned with question of interfaculty relations. It is clear that there are more interfaculty relationships now than there were ten years ago, and it is apparent that there is a current increase in them. We have labored hard and the fruits of our labors are visible in two pamphlets, "Tentative Recommendations Concerning Rights and Responsibilities" and "A Discussion Memorandum Concerning the Choice of a New President." I will not attempt to summarize them, but copies of them may be obtained from the Committee on Governance at Wadsworth House.

Would you discuss student participation on the committee?

The students came in with a great deal of enthusiasm. After about six or seven meetings they began to lose enthusiasm, so there was less and less participation as time went on. I do not think students are used to long, continuous meetings, and endless discussions.

Did they express any frustration?

No, I think they just felt that things were not moving fast enough. As a result of the formation of the university-side committee on governance, it was suggested that each faculty set up its own committee on governance. Dean Ebert appointed an ad hoc committee charged with considering the formation of a medical school committee on governance. It consisted of three faculty members: William V. McDermott '42, Cheever Professor of Surgery; K. Frank Austen '54, professor of medicine; and myself. Dr. Sidney S. Lee, associate dean for hospital programs, represented the administrative office. Kim Masters '72 and Thomas Mackenzie '70 were the student representatives. We had many meetings and believe it or not, it took us from 1 October 1969 to 11 March 1970 to produce a two-page document that described how we felt this committee should be formed. The document says two things: the committee on governance should be charged with reviewing the existing mechanisms of governance of Harvard Medical School in terms of function, efficiency, workers, patients, and organization. It should present recommendations for any changes in the existing governance of the School, if in the judgment of the committee they are desirable. The second major item of this document is the composition of the proposed committee. We finally decided on a committee of 27, smaller than the university-wide committee on governance. Our committee was designed so that all people who were concerned with the problems of governance could have a voice. We proposed that the HMS committee consist of medical and dental students, graduate students, post-doctoral fellows, house officers, alumni, a member at large, a member of the administration, a member of the board of overseers, and last, but I hope not least, members of the faculty. This committee on governance has not yet been appointed or elected. I hope it soon will be, and I hope it will start to function. The students on the committee that set up the committee on governance worked hard with us; they were important in pointing out the need for adequate student-faculty dialogue, adequate student-administration dialogue, adequate student-Alumni dialogue.

Dean Ebert and Dr. Blout

Dr. Blout was the final scheduled speaker on the panel. The following remarks were made by people in the audience who are identified where possible.

ARTHUR T. HERTIG '30
Shattuck Professor of Pathological Anatomy, HMS

I would like to ask Mr. Masters about the student composition of the SFC. I gather that the vast majority are apathetic, or of the so-called silent majority. I was on the SFC many years ago, during the "parietal rule" period you talked about. I am curious how you get dedicated students to give us all their time.

The SFC membership consists of two elected members from each class, the president and an elected member to be SFC representative. We also have a secretary, the women's representative, and a dental student. We do not have activists because they find the committee too slow. We do not have apathetic people because they are not interested in class office. What we have is the few percent of people in any class who are politically interested and not committed to any specific theories or ideologies, or any specific plans for getting things accomplished.

What percentage are elected by the student body?

Nine of the eleven.

What type of student would be elected?

I think the moderate student, one who is somewhat left of center.

What are your views about student representation on other faculty committees? Has your committee dealt with this?

Last year the committee arranged to put students on all faculty committees except the ones which were really important to students, such as faculty promotions committee and the student promotions committee.

How are the students selected?

They are selected by vote in the various classes. To answer your question specifically, I have some doubt about what committees students should be on. They should be on the curriculum, admissions, and financial aid committees, but I question if they should really be on the faculty promotions committee.

MANFRED L. KARNOVSKY
Harold T. White Professor of Biological Chemistry, HMS
Chairman of the Department of Biological Chemistry, HMS

I am not a member of this committee and in fact, represent the group of faculty who are not on any committees. During all the years that I was secretary of the faculty of medicine, the SFC was one of the least successful, most invisible committees to be formed during the academic year. Last year I was on sabbatical; on my return I discovered that the SFC had really come into the limelight, and had assumed a very real position in the community. I think it was beginning to attract a lot of sympathetic and respectful attention from faculty and students alike. The list of achievements and efforts that they have made is real; it is not merely on paper. On the other hand, I represent the vested interest of the faculty. I believe acutely in the right of the faculty, and the role of the faculty to lay down the principles under which it should teach and should conduct the university affairs, which are the faculty's prerogatives, to use a very bad word, or the faculty's skill, learning, erudition, competence and ability. Those are the things that I would like to see a faculty always free to rule on. I would like to see them able to elect new permanent members without any interference and without, perhaps, having students on the faculty promotions committee.

What would I like to see with respect to student participation in the affairs of the school? I would like to see a common interface across which can flow varying opinions, attitudes, advice, and reflections. I think the SFC, or any student organization that is in good apposition to faculty attitudes could reflect to the faculty a picture of itself, which the faculty has never really had. I also think the faculty can reflect back to the students, as it should do in any university situation, a picture that may be helpful in an educational and developmental sense. In my 20 years of teaching in this School, there is a much greater liveliness in the classes in the last couple of years. Either I have grown a little more educated to assess, appreciate, and listen to students' opinions; or there really has been an improvement in the ability of students to say cogent things that the faculty simply must look at, think about, and regard. As for the document on rights and responsibilities, I have to take some responsibility for the fact that it was thrown out by the faculty. I am glad it was, because what it did was to ultimately put, if not power, at least confidence, back where it belongs at this precise moment while we are in a period of reorganization. The SFC came away from the faculty meeting, which was quite turbulent and amusing, with a great deal of benefit; more muscle, more power in a sense, and certainly a substantial amount of well-wishing from the faculty.

There are many things we must guard against. We must be wary of accepting immature documents as the basis of the relationship between faculty and students. At the same time we must find a viable, broad-based way of talking to each other. I think one is developing; I think a good document will come in time. I believe that none of us should risk feeling illiberal because we do not want to accept or put our stamp of approval on immature documents which could hobble our relations with each other. There is still an opportunity in this world and in this School, for the average faculty member more right than I, and for the average student more left than Mr. Masters, to be able to talk to each other as human beings in a particular environment, to reach decisions, to iron out problems, and to come to conclusions.

Alumni listen to Dr. Karnovsky.

R. Michael Williams '73

I feel most students find the SFC completely unresponsive to their views and merely a ploy used by the faculty to throw a bone to those students having grievances. I will cite one example. You heard a speech by Dave Spiegel. That speech was not arranged by the SFC. It was arranged by a group of about 15 or 20 people who felt, after the mass meeting at HMS, that they had to take the situation into their own hands and do something about it. They simply went to the people who had the authority to make their own decisions, talked to the Alumni Council, and were able to convince them that this sort of speech was necessary at this point in our history.

I would take strong exception to the inference that the SFC was helpful in the confrontation of black students with Dean Ebert. The black students had an idea and went to the Dean. They knew the only way they could get anything done was to go directly to the administration's door and say, "Here I am, here is my problem." I believe that is the way we will have to deal with problems in the future. The SFC is perhaps more valuable in dealing with non-urgent problems.

Could I ask you what would be your suggestion as an alternative?

I do not think it is necessary to set up anything. I think we need bold and public statements such as those made by Dr. Karnovsky. I think we need more people who are willing to make statements on what their position is, and what their phone number is, and how they are willing to help. I believe Dr. Karnovsky is one of the most helpful people in terms of the strike activities. We did not need to go to a committee; we went to him and asked for help in arranging a way to mimeograph leaflets. He was first to help. I think it requires individual determination and ability to stand up for something. I think the administration feels their most important function is to maintain a smooth-running HMS. In order to do this, issues must be straddled and that is usually what the administration has done.

Joseph W. Gardella
Dean of Students, HMS

I regret having to follow what Mike has just said because I do not want to appear to be defensive on the part of the administration. Much of what he says is true, and I think as he sees it, it is all true. It is clear that the SFC is just beginning to get its feet on the ground and get practice in working out the problems. It is also clear that the administration cannot act ex cathedra; it has to have some communication with the general student body. The reason why Dean Ebert set up the SFC as he did was to provide representation for the views of the majority of the students. He turned over all his decisions involving students to the SFC to get a balanced view of student opinion.

Let us take the example of the black students coming to see the Dean with their demands. Dean Ebert's reception to them was warm and sympathetic. He listened carefully to their demands, and then he turned their document over to the SFC for their recommendations. In this process the recommendations came back with, I feel, a representative student view. The ultimate decision, of course, is the Dean's, but in each instance the decisions that he made have been consistent with the philosophy, views, and recommendations of the SFC.

Many administrators are trying to set up an effective means of communicating with the student body. When a group comes to an administrator and makes demands, the first question is, are they reasonable? If they are reasonable, they should be granted because no one could take exception to them. On the other hand, if the demands infringe upon the rights and responsibilities of others, then the administration must have some mechanism whereby it can balance the demands with the views and objectives of the entire student body. In the process, we in the administration have been accused of hedging, of running the school smoothly with no concern for how it runs, as long as it runs effectively. On the contrary, I think the administration has been active and most interested in getting students on the various standing faculty committees. We realize that often these committees make judgments on matters that directly affect the lives of students without any clear knowledge of what students think. It is quite clear with the caliber of student in this institution that we had better get students on these committees. And we have; they sit on all but three committees.

They are not on the student promotions board because the students themselves were not clear about whether or not they wanted students on the promotions board where intimate information about their colleagues would be revealed. They do not sit on the administrative board which is an arm of the faculty and has no provision for student representation. They do not sit on the faculty promotions board. If any of you feel these students are not mature enough to hold responsible positions on the faculty committee, I think you fail to recognize something of the nature of the modern student. These are not students who are trying to struggle with the older generation in terms of the father-son concept. They are a totally new breed of student, a kind of social mutation. If you do not recognize this, I think you are totally unable to understand the modern student. You cannot understand him on our terms. You cannot try to understand what he wants, what he is trying to do, if you attempt to use our values, our objectives, our goals, in the process. He is a person who, by common environmental forces I am not aware of, has emerged with a totally new sense of values. These students feel very strongly about moral and idealistic issues. They are genuine about these things. There is little or nothing in the way of selfishness in them. You have to

live with these students, I think, to even believe this. And when you do believe this, it is impossible to accept a decision from the Harvard faculty that such a person cannot make a significant contribution to the governance of this institution. In point of fact I have sat on no committee in which the presence of the students has not played a significant role in the immediate responsibilities of that committee.

We are coming to some kind of government, some kind of relationship with each other that is going to be different. I think we are in the process of reaching out for a new posture and we are having some growing pains at the moment. I hope within the decade things will be better. I do not know that we will ever be able to reconcile ourselves entirely with the young. I see, as I saw today in the vote of the business meeting, differences of opinion with the young that I think perhaps will never be reconciled. The best we can do is to come up with some order of co-existence less traumatic than it has been.

JOHN L. CAUGHEY '30
Associate Dean, School of Medicine, Case Western Reserve University

There are three points I would like to make. I am unwilling to accept the implied criticism of the silent students. The silent student is in fact living out what most people in this room have done, which is to consider medicine a demanding occupation. Many of them are sincere and capable people; some of them are frightened about the responsibilities they will encounter in the study of medicine. They feel they have to devote a great deal of their time to that study, and yet they are just as sincerely interested and concerned as the activists, though not as verbal. They are not confident enough of their own abilities to devote the majority of their time to activism. I do not want to accept the idea that the students who are not activists are necessarily culpable because of their inactivity.

The second point is that what is happening in this era, which is so difficult for all of us to comprehend, is that students downgrade the importance of experience. They are matching their feelings against the experience that has been accumulated by the faculty, and they would put the two things, their feelings and the experience of the faculty, on approximately equal terms in the decision-making process. That is very difficult for most of us to accept, whether we do at home or in the SFC.

The third point is that we are obligated to try to understand the area in which the student contributions are really important. I agree with Dr. Gardella that there are some areas in which the students do not have a really good basis for matching their feelings against faculty experience. It is related to something that Dr. Hunter said on the platform this morning. Decision-making without responsibility is a hazardous business. It comes close to being license. A student, after all, is a transient. I do not go along with the notion that students have the same power over the medical school as customers do at Macy's. If they do not like Macy's they can go to Gimbels. But students are transient; they do not have the responsibility for going out to raise money to meet the deficit. They do not have to live with their decisions beyond their graduation. And there are some areas in the operation of a medical school that require long-range responsibility. There are areas in which the feelings of the students are entirely valid in making decisions. There are other areas in which the experience and responsibility of the faculty are paramount. When the students are talking about their personal goals and about what they think are the needs of society, many of them are better qualified for opinions in this area than any member of the faculty. The people who want to work out these problems have to be reasonable in directing student interest in activities where the feelings and goals of the student are legitimate bases for decision-making on the part of the faculty.

Dr. Hunter considers Mr. Williams' view of the SFC.

Class Day

A peace banner with the caduceus through the "A" hung behind the platform during the traditional Class Day exercises. No black, but several red armbands were in evidence. No interruptions or demonstrations occurred but there was an addition to the formal program. Michael B. Millis '70, president of the class, read two statements to the audience. The first was a Statement Approved by General Class Meeting:

> We, the members of the Class of 1970, express our concern over the current American political, social, and environmental crises. Further, we urge active participation of the Health Care Community, as teachers and healers, in a reordering of national priorities towards the achievement of the following goals:
>
> 1. Provision of adequate health care for *all* Americans, particularly those for whom care is not now available.
> 2. Cessation of repression of political dissent.
> 3. Cessation of American military involvement in Indochina, and reallocation of national energy and resources toward the attainment of essential domestic social goals.

The second was a Minority Statement Submitted by Class Petition:

> In view of the nature of the times in which our Class Day occurs, we feel that we cannot let this occasion pass by without stating our views regarding the major issues of our day. It is clear to us that matters which might not seem primarily medical play an important role in determining how resources are allocated and, therefore, influence the quality and nature of medical care in the United States. We therefore issue the following position statement:
>
> 1. We most deeply regret the effort of our government in attempting to effect a military solution to political problems in Southeast Asia at the expense of constructive solutions to social problems at home and abroad. We support the efforts of the Congress to limit this misadventure.
> 2. We most deeply regret the efforts of the present Administration to silence political dissent, and we support those voices within the Administration that have already begun to recognize the disastrous consequences which will occur if present policy is continued.
> 3. We condemn the participation of our university in research programs and other activities which abet our misdirected foreign policy, and we request an overall re-evaluation by the university of both its research programs and its investment portfolio in order to determine if both are consistent with the principles upon which the university is based.
> 4. We regret the limited extent to which the medical profession has effectively addressed the issue of distribution of medical resources. We recognize and support the efforts of the faculty and administration of HMS in opening the medical profession to disadvantaged students. We also support those efforts made by the Harvard Medical School to remedy the problem of distribution of health care.

Dr. Millis receives Alumni Prize from Dr. Faulkner '24.

Eight members of the 181st class to graduate from HMS received honor awards for their work during the past four years. **Michael B. Millis** received the Harvard Medical Alumni Association Prize which is awarded each year to the permanent class president to extend a greeting from the old Alumni to the new, to accord respect to the graduating class by honoring its chosen leader, and to select for honor a man with whom long and cordial association is confidently anticipated. **Herbert C. Morse, 3d** received the Borden Undergraduate Research Award in Medicine for original research for his thesis "Biologic Properties of Rat Antibodies." He was also awarded his degree Summa Cum Laude in a Special Field, an academic distinction previously awarded only three times in the history of Harvard Medical School. The Massachusetts Medical Society Award for Outstanding Accomplishment was given to **William H. Burns** for his paper on "Viral Transformation of Kidney Cells." **Michael A. Gimbrone, Jr.** received The Leon Reznick Memorial

Prize for excellence and accomplishment in research for his thesis titled "Studies on the Role of Blood Platelets in Isolated Organ Perfusion." The Richard C. Cabot Prize for scholarly contribution to the history of medicine was given to **David J. Greenblatt** for his paper "Meprobamate: A History." **Michael M. Gottesman** was awarded The James Tolbert Shipley Prize for research, the results of which have been published or accepted for publication, for his paper "Kinetic Properties of Cobalt Alkaline Phosphatase." Earlier in the year, for the same work, he shared the Soma Weiss Award of the Harvard Medical Society with **Ronald H. Schwartz** who did research on "Investigations on the Role of the Macrophage in Determining the Immunogenicity of D- and L- Synthetic Polypeptides." The Louise B. Carr Avocational Award to the student contributing most to the general pleasure, relaxation and extracurricular fun of any or several segments of the Medical School's social life went to **Anthony C. Breuer.** The Rose Seegal Prize for scholarly contribution in the area of social and community medicine was awarded earlier in the year to **Sanford Ullman '71** for his paper "Relation of the Medical Profession to the Community."

The following awards were presented to graduates of the Harvard School of Dental Medicine by Dean Paul Goldhaber. The Harvard Dental Alumni Gold Medal was presented to **Vincent J. Abbatiello** for all round scholastic excellence. **Kenneth R. Diehl** received the Harvard Dental Alumni Silver Medal. The Dr. Norman B. Nesbett Medal went to **James A. Commette** for excellence in the field of dentistry. **Stephen A. Colchamiro** received the Harvard Odontological Society Award for the best senior student seminar. **Vincent J. Abbatiello, Stephen A. Colchamiro** and **Kenneth R. Diehl** received the Omicron Kappa Upsilon Certificate awarded by the Harvard School of Dental Medicine's Gamma Gamma Chapter of the national dental honorary.

Valediction

Robert H. Ebert, Dean

WE live in turbulent times, and there is a natural inclination to dwell on the trouble of this nation and the world, but on this day, which should be a happy one, I would like to strike an optimistic note.

Class Day is really Family Day — and it is to the families of our graduates that I would like to extend my warmest thanks. Thank you for the sacrifice you have made, for your understanding and support. And congratulations! The accomplishments of these men and women is one to be shared with you.

I should like to thank the faculty, who have participated in your education and who have continued to learn with you.

And, finally, my thanks to you, the Class of 1970, for your contributions to the School. Each class is similar yet unique, and each adds something lasting to the institution, for in the final analysis, it is the mark that each of you leaves that shapes the Harvard Medical School.

The second optimistic note concerns the future of this class. I say this more for the benefit of your families than for you. Whatever lies ahead in terms of social change, each of you will continue to have a vital role, for you will provide services that are essential, no matter what the circumstances of our society, and you will be recognized as important members of the community because of what you have to give.

It is difficult for a dean not to give advice — he receives so much of it from various constituencies that it would seem uncharitable not to share it! The advice I have to give is simple and obvious, but the simple and obvious is often overlooked in the pursuit of exciting missions. Remember that your wives or husbands and your children are "people" too and need an important share of your time, your energies and your affection. No matter how busy you are, how preoccupied, how deluged with work and responsibility, do not forget their needs, for if you do, you will have sacrificed needlessly one of your greatest rewards.

Finally, let me make an observation. You are now professionals and shortly you will be given diplomas to prove it. Your professionalization will continue as you pursue your internships, residencies and fellowships — and it is a process with many facets — some good and some of dubious value. But there is one aspect of becoming a professional that I should like to mention; it might be termed the release from the confinement of specific knowledge and technical skills. The ultimate work of the professional is that he is no longer bound by what he has been taught, no longer awed by the technical intricacies of his specialty, but rather is free to use or discard what he knows in the solution of real problems. Hopefully that is what you have been prepared to do — certainly you have the native intelligence to perceive your professional careers in the light.

The Care of People

M. Judah Folkman '57

WHEN I began to think about this Class Day speech I wondered what I could say that might be helpful as you begin internship and set your course for varied careers.

Perhaps, I thought, we could learn something from what would be discussed by a class day speaker of the future! As I moved across the years, I was struck by the Class Day speaker of 2070. I stayed to listen. Let me tell you what I heard, because there is a lesson of some value.

In 2070, the buildings and the Quadrangle look about the same. But the graduating class is small, only a handful; and the faculty even more diminished. So much progress in

biology has been made by this part of the 21st century that few doctors are needed. Babies are born free of defects and receive a single vaccine that protects them for life, against all bacteria, viruses and cancers. Only a few of Harvard's great hospitals are open; mostly empty, quiet and slightly unkempt, like retired ocean liners. Each maintains only one operating room for the few surgical procedures still necessary, but these are rare indeed.

Only the Affiliated Hospital appears to be new and modern. Of course its construction was completed just last year.

The curriculum itself has been shortened to 6 months. At the turn of the century, "injectable knowledge" was discovered. Injections are given intravenously in the first week of school and the remaining months used to make sure that the injectable material has appeared in the brain. Occasionally a bad batch arrives from the manufacturer and students are detained several months. At these times old alumni reminisce about the ancient habits of reading and studying. But these skills have long since been abandoned as too time consuming and inefficient. No one knows how to do them anymore. They were part of a former classical education, taught until the turn of the 21st century.

In the wake of these tremendous achievements, most departments in the medical school have become abbreviated. But the admissions committee in the year 2070 has grown. Doubled its size. It is large, busy and affluent. Students still must be selected with the greatest care because much of the population is violently allergic to injectable knowledge.

However, even the admissions committee is apprehensive, because each year there are fewer and fewer applicants. This is partly because there are fewer positions available for graduates, and partly because even these opportunities are *routine, prescribed,* and *unchallenging.* The few remaining physicians work either in the empty, still-life hospitals,

Dr. Folkman

or in the occasional centers, placed in strategic parts of the country, called Medical Bureaus of Standards. Physicians are needed to watch over elaborate equipment that monitors any unexpected epidemic. But such outbreaks rarely come. These men do not think of themselves as technicians, but that is what it says on their salary checks.

The Class Day speaker of 2070 then looked back and reviewed for his audience the marvelous, miraculous medical accomplishments that had eliminated disease after disease, prolonged life, and prevented suffering.

But then a certain sadness slipped into his voice. And he lamented. He deplored the absence of challenging problems. There really were *no major* problems left (as there used to be in the good old days). He looked at his small audience and pointed out how few men entered this sacred profession anymore. This great profession was once preeminent because it seemed the most responsive to man's perpetual need for new solutions. And he concluded, solemnly, that the only salvation he could think of was for the Dean to appoint a committee to make up some problems; devise some challenges.

This was hailed as a superb idea, a brilliant new approach, a masterful speech. It was printed in the *Harvard Medical Alumni Bulletin,* and other schools wrote for copies.

But as an outside observer, *I* could see that the class day speaker of 2070 was not entirely accurate. In fact, there was already a plethora of problems, most of them direct by-products of the very advances in medical science and biology to which the speaker had paid homage! The mastery of the heart of biology which had subjugated disease, had also, strangely enough, given mankind the ability to control sex, to control intelligence, height, color, and myriads of other characteristics. Governments and nations struggled and were weighed down by these seemingly endless enigmas.

Physicians, however, were never consulted about these. There was no physician who was either concerned *or* knew anything about this kind of problem.

Not that the physicians of 2070 failed in devotion. To the contrary! Each cared for his patient with the ultimate of compassion and scientific insight. Each had on his wall the Oath of Hippocrates, and on his desk the classic paper by Francis Weld Peabody which said that "the secret *of* caring for patients is to care *for the* patient."

But somehow, imperceptibly, many, many years ago, the medical profession reached the conclusion that this alone — the compassionate and scientific concern of each physician for his patient — was the *limit* of a physician's responsibility; that the *care of people* was someone else's responsibility.

The origin of this decision is obscure. There had been years of debate. Many had hoped that the diligent devotion, which was the hallmark of the physician-patient relationship, could be extended to people. But proponents of the narrow view feared that such a strong pull in the direction of *people* would dislocate the code by which medi-

cine had been practiced since its beginning. Those who espoused this narrow view had won.

I left the Quadrangle on that day in 2070. I made my way back through the years and I thought about your graduation. I thought, how fortunate you are as members of the class of 1970. That (fateful) narrow decision has not yet been made. The choice is still yours and you can choose a different road. Many of you already have.

How fortunate that I do not have to lament a dearth of problems for you to work with. I do not have to ask for a committee to find some for us.

You and I and all physicians face an array of knotty dilemmas that crowd in upon us.

One can recite a litany:

Our difficulty in changing the delivery methods of medical care to meet the needs of large and poor communities. Dr. Barkin has just discussed this.

Millions of our people cannot obtain the services of any doctor in a small town, or at night, or that they can afford.

Even those who live near large medical centers cannot find their way into the sprawling system without a personal guide (often a son who is a medical student or resident).

We have been unable to prevent the gradual division of our profession into *two* camps: Those physicians whose continued education is guaranteed because of staff membership in a large hospital . . . and those who are denied this because they cannot obtain these privileges.

Our inability to care for our accumulating numbers of aged and mentally ill.

Our seeming incapacity to govern ourselves, to police ourselves within our profession, to control our quality, judge our peers, and prevent abuses.

And on and on.

Many older alumni here today, listening to this litany, must shake their heads in dismay. Are these not the symptoms of irreversible decline, of the terminal days of a once *proud, privileged* and *pre-eminent* profession? We seem as helpless as a meteorologist in the presence of an advancing hurricane — he can plot its course but has no means to divert it from its path. Some, in fact, may pity you. They might not want to be in your *shoes,* just beginning their careers again.

But *I,* not so far ahead of you in age, *envy* you. These are not the problems of failure! These are the problems attendant upon previous success. Persistent, startling, miraculous success. From penicillin to polio vaccine, from safe anesthesia to surgery in the heart.

My father, speaking for the clergy, pointed this out to me a few years ago, when I told him some of the difficulties which I thought were encumbering the medical profession. "Aaahh," he said, "if we in the clergy could only have such problems. What a profession *you* have. Your clinics and your hospitals are jammed and crowded with people waiting in line for your help. Our churches and synagogues are empty."

Maybe he was right. Our people seek more of what we offer, and we scramble to keep up with the demand. Our effectiveness in relieving human suffering is now visible. And no one wants to be neglected.

The litany of problems is of recent origin, but so is this effectiveness in altering nature.

Before the turn of this century our profession brought to human suffering all the compassion it could muster, but little scientific insight. In that time no one expected more of his physician. The respect of our people for physicians of that age is epitomized in the famous painting, THE DOCTOR, by Luke Felds. A 19th century physician in frock coat sits for hours by the bedside of a dying child, with grieving parents in the background. The public sees his compassion.

By the middle of this century we had combined compassionate care with really good scientific principles and the results were staggering. The painting now has a sequel because the child recovers. It becomes clear for the first time that we can alter the course of events to reduce death and suffering, not just occasionally, but repeatedly. No better is the contribution of this generation illustrated than in the work of the distinguished faculty who have taught you. Basic scientists and clinicians together have drawn a map so that you will not lose your way.

But now our people yearn for a *new* generation of physicians. The challenge before *you* is even more exhilarating than before. To help alleviate human misery and suffering, you can select not only from the many puzzles of still uncontrolled disease but *also* from the array of peculiar problems that I have described.

Many of these are social problems, but not all! Most have a common origin in our past successes, but not all!

However, *all* of them are "people problems." Their solution has a common requirement. THE COMPASSIONATE AND SCIENTIFIC TALENT WITH WHICH WE CARE FOR INDIVIDUAL PATIENTS NEEDS TO BE ENRICHED BY EXTENDING THIS CAPACITY TO PEOPLE!

To every class before you we have taught the credo of our profession — that each patient receive the best of devoted care and scientific skill.

We now propose an amendment — that you extend these unique capacities to the care of people.

Whether your life's work be investigation, bedside care, public health, teaching or whatever, there are plenty of chapters in the book of "people problems." Why not take one for your own? Become fluent and familiar with it; be active about it. Many will take on more. But I hope none of you will begin your travels without at least one.

You must be thinking . . . "that's all very nice, but I can't start worrying about those things until I get through these next years of intensive

hospital training. Only the patient will have to be my concern night and day!"

I think you *can* begin. Begin at once to be a physician for patients and people. I will give you one brief example, because I am confident you can figure out the rest for yourself. When you start internship you will see that one of the demands that our profession has tried to meet is to bring the physicians' talent to more and more patients. You will be assisted not only by nurses, but by blood bank technicians, x-ray technicians, social workers, operating room assistants, physiotherapists, ward clerks, orderlies, aids and so on. You can say to yourself . . . the patient alone is my responsibility . . . all these ancillary people are not!

Or, you can recognize that although the satisfactions of your career come from your patients, the people who help you are often more distant from the patient. They depend upon *you* for the satisfactions and rewards of their careers. When a little child returns to your clinic or office, healthy again, with happy parents in tow and a present for the doctor, the nurse or technician who may have helped in the hospital care is not there. Occasionally you can let them know that this little patient might not have made it without their help. No pay raise or fancy title can substitute for a word from you about a job well done.

If you choose this path, then you will understand why my farewell message to you is similar yet *very* different from that classic quotation of Francis Weld Peabody. I hope that in emulating his lesson, you would add another sentence. "The secret of the care *of* people is to care *for* people."

If we as a profession learn to care for people as well as we have for individual patients, then we can begin to solve the problems set before us.

If we do not, then someday we will no longer be asked; and that pathetic class day of 2070 may unfortunately come true.

Confrontation and Change

Roger M. Barkin '70

THREE weeks ago, students at Harvard University were on strike, not because of pay or working conditions, but in mourning for the four dead students in Kent, Ohio. The protests have mounted and the shootings have continued. Eight black youths have lost their lives in the growing unrest that has overtaken this country and clouded the exhilaration that would normally accompany this Class Day. "Americans everywhere have had a growing sense that something is very wrong," John Lindsay said after the Kent shootings. Distrust, frustration and dissent abound. Consensus and optimism have disappeared; disillusionment has overtaken the youth and the disadvantaged, and has even penetrated the great "silent majority." The gap between hope, promise and aspiration and reality has widened. Indeed, it is a moment of crisis in America — the crisis in Southeast Asia, the crisis in the cities, the crisis in race and education, and the crisis in medicine.

A sense of urgency pervades; the American people are responding. The voice of protest is being heard and the Establishment is awakening. The community being served is demanding participation in the decision-making process. As undergraduates, many of us saw the evolution of what came to be called Student Power. Students, as consumers of education, demanded a voice in that education, just as the American citizenry is now demanding a role in determining its national commitment in Southeast Asia. As the consumer of medical care, the patient is turning to the inadequacies of the health care system. Patient power is finally becoming a reality.

Medical care has traditionally been a passive, after-the-fact event. The consumer has remained unsophisticated about health care. The doctor has, in large part, determined the need for services and facilities within the system. In resisting real change, the medical profession has emphasized the uniqueness of the physician in dealing with disease.

Fatalism has pervaded the health care system. A resident of Columbia Point in Boston summarized her interaction with the medical profession as follows:

> You are going to let me provide the illnesses and you are going to run the services.[1]

Another observer declared:

> To the doctor, "the body can be seen as simply another class of objects to be worked on but not repaired."[2]

Consumer passivity has finally ended. Medicine has become an instrument for social change and the consumer is demanding a voice in the planning and execution of medical programs. The poor have no access to health care and the wealthy are being shuttled between specialists, the emergency ward, and the fragmented hospital. Access, coordination, and continuity of care are absent.

The medical profession previously enjoyed relative immunity from its political and social milieu. Medicine is presently being pushed into the community; if it does not respond, the community will pull it in as they did in Oceanhill-Brownsville in New York City when education became an issue. If the purveyors of medical care are passive, the community will be active. Confrontation looms heavily in the future of medicine if the profession does not become more responsive to its constituency, the patient.

The initial response of the medical profession to the challenge of improving health services has been disappointing. "Though vocal on the need for change, medicine has remained largely silent about the direction of desirable change."[3] Expansion has been government policy.

Improvement has been equated with a quantitative alteration in facilities and manpower, but no real change in services. Little, if any, real effort has been made in a qualitative and meaningful re-evaluation beyond the simple principle of multiplying existing facilities.

Medicaire and Medicaid were key bills in the expansion of health services to groups with minimal access, but they were primarily efforts to throw more money into the pot of spiraling costs without positively altering the system. There was little concern about the ability of the medical system to absorb the additional patients who now had access to funds for medical care. Hill-Burton provided for hospital construction with few limitations and virtually no direction. Regional Medical Programs tried to bring some order to the chaos but so far has failed because of its inability to exert real leverage. The 1966 legislation instituting Regional Medical Programs contained its own internal restraints:

> Regional Medical Programs were to proceed "without interfering with the patterns or the methods of financing of patient care or professional practice."[4]

Real change had thereby been effectively legislated against. "One cannot change, without changing."[5]

New ideas remain experimental and lack coherent direction. Neighborhood health centers are multiplying to fill the voids in low income areas, auxiliary personnel are being used in pediatric and chronic disease settings, and group practice has been evolving into comprehensive care programs. However, we must be wary of having experimentation become an end in itself, rather than a means to an end.

Tokenism has been the motto in health care's efforts to provide services in the community, as well as to involve them in the decision-making process. The failure of the Affiliated Hospital Center to provide for the community it was displacing is a striking example. The Center was originally designed to coordinate

Dr. Barkin

the resources and bring together the diverse specialties encompassed in the Boston Hospital for Women, the Robert Breck Brigham and the Peter Bent Brigham Hospitals. The initial plans called for neither an increase over existing ambulatory facilities nor alternative housing arrangements for the 100 odd families whose homes were scheduled for destruction. Nearly 12 months elapsed before the hospitals accepted the legitimacy of community participation in the Center's planning. A dialogue has finally been established — it remains to be seen whether or not it will be a meaningful one and deal with mutual health care problems.

Politicians, educators and now health professionals have seen the community demand responsiveness and accountability to its demands. Health care has become a right of all and services must begin to reflect this. More personnel, more facilities, and continued duplication of the chaos that confronts us is certainly not the answer. "The availability of money doesn't produce resources where they don't exist."[6] As new physicians, we will face the community in the hospital, in the clinics, and in their homes, and we must realize that if medicine does not move in the direction of making real substantive changes, community confrontation is inevitable, as we saw in the Oceanhill-Brownsville section of New York City.

Political decisions affect the urgency and direction in which change will evolve. The community, whether it be the student, the political activist, or the patient, holds the real power with regard to influencing the political process. As we enter into the medical profession today, we must accept the community as an ally, rather than an antagonist, in achieving an improved health care delivery system. Working together, the two groups can influence the political process and evolve a responsive health care system. Working separately, confrontation seems to be inevitable. The choice is both a personal and a group one. In the years ahead, it will constantly face us. Order must be brought out of the disorder of the present delivery system. In this task the community will be our strongest ally.

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The Other End of the Stethoscope

Hardin C. Jones '73

Introduction

"The preamble to the constitution of the World Health Organization defines health comprehensively as a 'state of complete physical, mental, and social well-being,' and not merely the absence of disease and infirmity."[1] With this definition in mind, I feel that it may be of value to review my recent experiences as a patient. The purpose of this paper is to describe some of the inadequacies of hospital care as they became evident to one "on the other end of the stethoscope," fully aware of his general lack of knowledge of the reasons for some of these inadequacies.

This study draws on my personal experiences. Anticipating a career in medicine, I critically examined the procedures, attitudes, and interactions around me. I recorded my experiences and impressions in my daily journal and have selected a few, unedited excerpts in the hope that they may be of some help in pointing the way to better health services. I believe the perspective acquired from this study has been unique.

The names of all persons mentioned have been changed.

Sketch of Medical History

I was accepted to Harvard Medical School in January 1967. That spring I was severely injured in a motorcycle accident. My left leg was crushed on impact, and I sustained brain stem injury as well. I was rushed to the intensive care ward at the University of California Medical Center at San Francisco, where I remained in a coma for two weeks and was not expected to survive. I was hospitalized for a full year (May 1967-June 1968) and recurrently throughout the following year.

My neurological problems, total retrograde amnesia, severe motor dysfunction, and severe intellectual impairment, have slowly but fully disappeared.

My orthopedic problems, unlike my neurological ones, have become progressively more complicated. I have been operated on 14 times, in body casts for 13 months, and in traction for four months. During the periods of my release from the hospital, I have been on crutches due to chronic non-union of the femur. There have been recurrent symptoms of infection, further complicating the treatment, and only since my referral to the Massachusetts General Hospital (March 1969) has the infection been controlled. In May 1969, my femur was bone grafted and pinned.

The outlook is favorable though there are severe secondary problems caused by scar tissue and immobilization of the knee and ankle. I have been in a one-leg body cast since my last operation. I was married in July 1969 and enrolled in HMS last fall, attending the first three months of classes in the cast. I am out of plaster at the time of this writing (April 1970) and anticipate being off crutches soon.

I. The Clinical Physician

The goal of the physician is "good patient care." Unfortunately, to this phrase are ascribed many different meanings. Doctors rightly direct their talents to the cure or amelioration of disease and the relief of suffering. Because these technics are arduous and time consuming, the personal problems of the patient are often distracting.

The problem of patient care is compounded by ever expanding technical competence. The phenomenon of accelerating specialization in medicine has resulted in the modern physician's inability to provide comprehensive health service.[2] The orthopedic surgeon is interested in problems of bones and joints, and sometimes doesn't want to be involved with the psychological or emotional problems of his patients. Like other specialists, orthopedic surgeons enlist still other specialists to examine and treat symptoms not related to their own field. With the compartmentalization of treatment, the overall health and welfare of the patient is easily overlooked.

This section will explore the problems of medical education that result in less than ideal patient care.

Medical schools often graduate physicians who are neither equipped nor suited for the personal contact that clinical medicine requires. And yet, it is the responsibility of medical schools to counsel students in the personal needs of patients. Students with poor rapport might be redirected into the medical sciences (where personal contact is not a critical factor) or should be further trained in the art of bedside manner. Some young physicians have a facility for perceptive personal relations. Others have not. Yet, like public speaking, all can learn the skills. Such doctors would not be frustrated by inadvertent alienation of patients.

Two residents of my experience exemplify the grief engendered by an inept bedside manner. Both were frustrated by their inability to realize their self-image. Perhaps neither recognized the source of this frustration. One of them, whom I shall call Edwin Blackwell, adopted a distant, tersely professional manner as a defense for his lack of self-assurance. His "coolness" in turn cooled the nursing staff and patients. This rejection further compounded his nervous defense. Getting to know Dr. Blackwell better, it became apparent that he was a sincere, but lonely, young man.

My second example of poor professional technique and the associated anxiety is Dr. Franklin Cooke, a second year resident in orthopedic surgery. Dr. Cooke was trying to create an image of dynamic assurance with heroic capabilities. He was constantly cancelling drug orders without consulting the patient.

On one occasion, he unwittingly changed "suppository days" from Monday-Wednesday-Friday to Tuesday-Thursday when renewing weekly orders.[3] This cancellation caused several patients who expected to go home for the week end the inconvenience of being unprepared and they had to delay their departure.

Not only was Dr. Cooke clumsy with the book work associated with clinical responsibilities, but his heroic bedside manner was a disaster. He was confidently describing my roommate Tony's medical history and suggesting possible treatments. Tony, who had broken his neck in an automobile accident and is paralyzed from his shoulders down, awoke and asked what was being planned. Dr. Cooke smugly replied, "nevermind." (Nevermind PATIENT, we DOCTORS are busy.) Tony stared up in disbelief and later commented about his dismay and exasperation with our disdainful young doctor. By the end of this resident's rotation, most of us resented him.

Dr. Cooke's genuine concern for his patients' problems was overshadowed by his concern for promoting an image of smooth, professional skill, a doctor who would win the respect and admiration of all. He should be told that a patient needs and appreciates his physician's cordial sincerity most. Professional competence is certainly a prerequisite for effective patient care, but Dr. Cooke's theatrical dramatics belong only to television soap operas.

These unnecessarily awkward technics are in contrast to the successful attitudes of Drs. Adler and Stuart, both confident, friendly men. Dr. Adler, the resident before Dr. Cooke, had an assuring professional style. When presenting patients on rounds, he spoke of his patients with personal reference and encouragement. Likewise Dr. Stuart was relaxed and friendly in his manner. On staff rounds he eased the tensions of his patients by sprinkling his dialogue with praises of their efforts and accomplishments.

A doctor must be honest with his patient, but should guard his words to avoid unnecessary worry. Physicians must especially avoid offhand remarks. The patient confined to bed is anxious about his health and spends the day mulling over the doctor's recent remarks. He lies and thinks, interprets and struggles all day, developing all possible implications suggested by the doctor's words.

Equally dangerous is the inept wording of questions directed to the patient by any of the professional staff. The following is an excerpt from my journal describing the tactless questions asked one of my roommates, Jeff, whose neck was broken in an athletic injury:

April 19, 1969: Jeff was presented in group seminar four months ago to an audience of doctors and medical students. He was asked several tactless questions such as, "How does it feel to be a quadriplegic?" — How can that question be answered? How? — Such artless technique can be avoided and still obtain the desired information. Questioning should be directed along rather specific lines; the rest will follow. Ask specific questions about the patient's problems, questions that can be answered. The patient's concern (attitude, worries) will surface. For example, instead of asking how it feels to be a quadriplegic, the skilled inquirer, noticing Jeff uses a wheel chair, might ask, "Jeff, I see you get around by yourself pretty well in your wheel chair. Have you tried wheel chair transfers?" — Yes, the patient gets around pretty well but (red faced) he cannot manage to lift himself in and out of the chair alone.

A shrewd investigator might infer from the patient's response that the quadriplegic is distressed with his dependence on other people. In any event, questions such as, "Does it bother you not to be able to control your bladder?", "How does it feel to be sexually impotent?" and "How does it feel to be a quadriplegic?" should be avoided.

Unfortunately, physicians have taken a removed attitude and visit patients on rounds with a few professional words concerning medical progress and planned treatment. They should be more careful in their counsel. Medical training must prepare physicians to treat patients, not physical disorders.

In my own case, being a healthy young man totally immobilized, I was disturbed about my decrease in, and almost total lack of, sexual drive. Unable to rationalize my dilemma, I concluded that I must have been experiencing sexual failure about five decades before my time, or perhaps was being fed a diet heavily seasoned with saltpeter. I was too ashamed to verbalize my struggle. Fortunately, the problem worked itself out over a period of a year. Looking back, it seems amazing that my doctors did not prepare me to handle this crisis.

As with the sexual dilemma, doctors must advise their patients on the use of the bedpan. Many hospital patients are confined to bed, having had no experience with these unpleasant and unwieldy contraptions. As any who have tried it can document, it is quite difficult to move one's bowels lying out flat. After several months in a full body cast, I discovered that the whole business was made easier if, upon awakening, I began tightening my stomach and bearing down at intervals.

It should be standard procedure for doctors to orient their patients before problems occur. A few timely words by the physician would save the patient much unnecessary agony. Those who already understand will not be offended by the physician's professional, yet personal concern.

Another common shortcoming of medical education is the failure to train future doctors to call in consultants when difficulty is first encountered. I have seen physicians

pursue a fruitless line of treatment. When failure became evident, they failed to call on their colleagues for consultation, and continued the same hopeless strategy. It should be standard procedure to call consultation on difficult cases *before* hopeless complications are engendered.

Besides considering other professional advice, physicians must consider the patient's views and explanations instead of discounting them, as so often happens. This thoughtlessness of attitude and incomplete investigation can have disastrous consequences. During his early hospitalization, Jeff was fitted for a halo.[4] He complained that the body cast was too tight. His doctor scoffed and said that Jeff was mistaken because, after all, he was a quadriplegic and did not have sensation in the chest area. Thanks to the doctor's close-minded approach, Jeff's skin broke down and his planned spinal fusion had to be delayed until the sores healed.

Another of my companions fitted for a prosthesis experienced a similar problem. He complained that his artificial leg was irritating the skin above the amputation. "Impossible, the prosthesis isn't fitted that way." Fortunately, this fellow's skin did not break down, although he was forced to remain in bed for a few days while the abrasion healed.

I would attribute physicians' failings in the practice of clinical medicine to: egotism, routine, and specialization. All doctors seek some level of ego gratification. It is inherent in the selection process that those who survive and proceed through the rigors of medical school are achievers and competitors by nature. Furthermore, the prestige of the doctor is realized in our society from a very early age. The toy doctor bags and stethoscope of the young child are further glorified by the T.V. images of "Dr. Ben Casey," "Dr. Kildare," and the serial episodes of "General Hospital." After medical school, the powerful image of earlier days is reinforced by the ego-expanding realization that the physician sometimes holds the balance between life and death. While this realization is a great burden and responsibility to the conscientious physician, it is hard to resist the subtler attractions of such responsibility. For example, the typical hospital patient idealizes his doctor . . . "Yes, my doctor, Dr. Blanchfield, is so marvelous. If it wasn't for him I don't know *what* I would have done. Why just this morning . . ." and on and on. It is little wonder that the doctor has a tendency to assume divine power and privileged knowledge.

Many mistakes would be avoided if physicians were aware of the ego pull of practicing medicine. The humble, yet confident, doctor would be more inclined to call consulting help, more likely to consider the total aspect of the patient's disorder, and more apt to encourage a positive outlook by the patient. The skilled, but overworked, doctor is apt to regard the patient as a complication of the treatment. I contend that the patient's will power, determination, and natural bodily defenses are the major factors in effecting any cure. The doctor is there to counsel and to render technical assistance.

Routine contributes to the failings of clinical medicine. There is a tendency to regard the patient's general condition as static, and to focus only on the disorder of primary complaint. For example, an unobservant specialist might overlook the progressive swelling of an elderly patient's ankles and legs, which might remain untreated with fatal results.

The most recently developing, but most easily corrected phenomenon of modern clinical medicine, precipitating discontinuity of medical care, is specialization. Because of the accelerating degree of specialized endeavor with the pile-up of medical technology, the total aspect of the patient is easily overlooked.

The coordination of medical service is a much talked about but highly elusive facet of modern clinical practice. There are no physicians or medical specialists presently capable of dealing with the general aspects of health and disease.[5] Yet, medical care could be easily integrated under the present structure of clinical medicine. I have witnessed what is perhaps the most easily initiated program of coordinated medical care. This program requires neither special training nor major alterations within the present clinical structure.

Dr. Everett Williams coordinates clinical care with the aid of nursing personnel. Specifically, Betty Manning, his surgical nurse, makes her daily rounds. During her visits the personal problems of each of his patients are taken care of. She then consults directly with Dr. Williams. Doctor and nurse then consider what should be done and arrange for any necessary consultation on the patient's behalf.

Dr. Williams also makes his own daily rounds. Much time is saved in his busy schedule as he already has a report of the patients' problems. He still regards the care of the patients as his responsibility but is much more efficient in handling their needs.

His nurse provides the necessary ingredient of this proved system. Whereas doctors' professional and "never time to talk" attitude on rounds is not conducive to having the patient reveal his concerns, with Betty, the patient realizes that interest is in his total well-being, mental as well as physical.

Other such systems using nursing or allied health personnel could be completely successful. The nurse would generally coordinate patient care, follow through complaints and treatment, and report directly to the doctor in charge, who could then arrange for necessary consultations. The doctor then makes the most efficient use of his time; the nurse facilitates the patient's total care. The patient is satisfied that all of his troubles have been aired and are receiving proper attention.

II. The Nursing Staff

Nursing care is equally important in building a positive patient attitude. The brunt of the patient's adjustment to hospital life necessarily falls on the nursing staff, since nurses

are in constant contact with the patient.

The basic qualifications for a nurse are consideration for people, sacrifice, and devotion to her profession. Nurses must be flexible to meet the demands of the whole spectrum of hospital patients, and must be prepared for the frustrations presented. The typical patient is anxious about the details of his own illness and is often short tempered in his insecurity.

It seems that each patient chooses one particular nurse to be his favorite. This alignment performs the double function of stabilizing his anxiety (i.e., he has someone who is truly interested) and satisfying the individual nurse's desire to know that she is appreciated. Thus, beyond the requirements of professional proficiency and of sacrifice, the personal traits of the individual nurses pair up with the patient's individual personality requirements.

III. General Patient Care

A general description of ward activity and the guidelines for realizing effective patient care should be considered.

The typifying characteristics of hospital life from the patient's perspective are those of delays, lethargy, and routine. It is often difficult for the novice to adjust to this drudgery, but once the transition is made, few other problems are manifest.

There are several factors contributing to the slow pace of mental activity. The patient confined to bed, having no physical exercise, becomes lethargic, constantly groggy, and drained of his reserves. Furthermore, the typical hospital patient is interested only in his own immediate problems. The unending discussion and dramatization of one's own medical details I have termed the "hospital syndrome." This narrowed concern and interest excludes all other mental pursuits (except perhaps the stimulation of day time T.V. quiz shows and soap operas).

Other factors contributing to the slow mental pace are the frustrations of continual waiting and constant interruption. The novice admitted to the hospital expecting a flurry of clinical activity is sadly disillusioned. The physician, after completing the routine history and physical examination on the afternoon of admission, suggests to the patient that a number of diagnostic tests will have to be run and that the necessary orders will be written. The next morning upon awakening, there is breakfast, washing, changing of linen, and medications. Perhaps your roommate is engaged in an exciting T.V. episode of "The Beverly Hillbillies," or is pestering you for the details of your medical problems, so he will not feel uneasy describing his own. Shortly before lunch the technician from the hematology lab wants a blood sample. After lunch and two hours of flipping idly through a *Readers Digest* that was left on your night stand by the last patient, a nurse rolls a wheel chair into the room and smilingly announces that x-ray is calling for you. Finally, action!

So you get comfortable in the wheel chair, anxious to be on your way. There is a 20-minute wait for the messenger to escort you to x-ray. When you arrive, a woman takes your chart, smiles, and informs you that there will be a short wait. During the 45-minute wait you fumble through the pile of ancient magazines on the rack next to you. Nothing catches your eye. About this time the white-coated technician guides your wheel chair to the waiting x-ray chamber. After passing through the sliding leaden doors, the technician helps you to the table and positions the first plate. After 10 minutes of, "Hold. Don't move, don't breathe" . . . whurr . . . "All right, breathe," you are wheeled back to the corridor and told that a messenger will be called to take you back to your floor . . . a 25-minute wait, no, 35 . . . and you are back to the room in time to hear your chance companion, Mr. Johnson's half hour description of his Aunt Gertrude's gallstones, suggesting that the propensity for gallstones is congenital, but then Mr. Johnson explains that he is in for kidney and bladder stones not gallstones . . . still he rambles, there may be some connection.

During Mr. Johnson's kaleidoscopic journey through the land of bladder stones, your mind is trying to anticipate what today's x-rays will indicate. — Dinner — The Huntley-Brinkley 6:00 news is on the air, but does not seem nearly as exciting as the Excedrin commercial that reminds you that you have a headache and feel worn out. Ah. You hear your doctor's footsteps approaching . . . the room across the hall.

After an impatient 10 minutes, Dr. Murphy is standing at the end of your bed explaining that your blood tests were inconclusive and that the x-rays suggest a slipped disk. The radiologist has also detected shadows that might be gallstones, but more x-rays will be necessary in any event. So . . .

Armed with this new information and its infinite possibilities and implications, you now enthusiastically begin a monologue of your own, but notice that Mr. Johnson has fallen asleep with the T.V. on. So, it's back to the *Readers Digest*. Somehow the "Most Unforgettable Character" is forgotten in the quandary about gallstones, although Uncle Rupert once had yellow jaundice, and Cousin Myrtle . . .

Even for the occasional patient who has a planned program of intellectual activity (school work, business correspondence, or the library of novels put aside these last years), it is difficult to battle the constant interruptions and distractions of

ward activity. In a private, or semi-private room it is possible to capture a few scattered moments to one's self. In a four-bed room or larger it is totally impossible, especially when both televisions are constantly on . . . on different channels, and the third roommate is tapping his headboard with his fingernails in rhythm to the latest on the soul survey. Furthermore, hospital routine — medications, wash, bedpan, linen, doctors' rounds, nurses' rounds, meals, mopping floors, bringing of fresh ice water, etc. — is inescapable.

Hospital rooms are notoriously small. Although roommates provide companionship, there is *no way* to avoid unwanted conversation. There is no way to be free of a distasteful roommate, and the forced submersion in an unchosen stranger's worries, words, and complaints can be unbearable.

This general description of ward function is the prologue to the larger discussion of effective patient care. The most important criterion of effective patient care is building a positive attitude, the attitude necessary for the patient to realize maximum recovery, rehabilitation, and readjustment.

The major problem in building a positive attitude is overcoming the patient's feeling of alienation and isolation. The artificial environment is made more homey by the staff's understanding of the problem. Much can be done to minimize the existing emotional barrier.

Perhaps the most difficult barrier for the patient to tolerate is the physical one. In that antiseptic world no contact is allowed (not sexual contact necessarily, although sexual isolation is a real problem). A few entries from my hospital diary would be more illustrative than any description I could offer now.

> May 11, 1969: Back rubs are a necessary part of patient care. The personal contact, the touch, is reassuring in this otherwise sterile world.
>
> May 23, 1969: I've had a burning, wracking need to be kissed these last four or five days. Wow. I could fall in love with my T.V. set if it could only touch my arm, my face! Physical isolation is uncomfortable! — Back rubs are the only contact. Even that professional contact is craved. I need to be needed, to hold someone, even a teddy bear, in my arms, against my chest.

Unwittingly, doctors can intensify the isolation felt by the long-term patient. My friend Jeff lay drenched in perspiration recovering from another of his uncomfortable episodes of uncontrollable chills, and confided in me that doctors were useless. He complained that they were satisfied with the explanation that "sweating is just something that quadriplegics do."

Maybe Jeff was right. What good is an explanation as empty as "something non-normals do?" An alternate explanation could have proceeded as follows: The doctor could sympathize sincerely with the patient's problems, recognize that medical science has not discovered the answer, and offer the hope that the solution would someday be found.

Equally frustrating as the "something 'they' do" is the "it could be worse" reaction. The typical reactions of the ignorant (including doctors) on meeting someone with a severe handicap are: "It could be worse," "at least you have your mind," "at least you're alive." What good are these empty statements of the obvious to the handicapped? The stranger or doctor, feeling he has done his part to relieve suffering, picks up his hat and steps into the outside world. Meanwhile our comforted patient sits in his wheel chair, or lies on his sweat-soaked mattress and ponders the consolation that it could have been worse. He could be dead.

Contrast the above with the skilled but genuine sensitivity of Mr. Brown, a visiting social worker. First he recognizes the individual's handicap by agreeing with the patient that it must be pretty rough . . . nothing complicated, perhaps a simple "yeah" and a grimace. But the recognition is there because Mr. Brown has neither overstated nor whitewashed the problem as the patient sees it. He has won the patient's confidence and they now can proceed comfortably with conversation, perhaps to the outside world, or sports, or girls, or "normal" life.

On the other hand, excessive indulgence in the patient's problems is both unhealthy and unsolicited. What the patient needs is laughter, not tears and the flood of sorrow indulgence brings.

There is one aspect of the "it could be worse" reaction worth mentioning. The patient's verbalization of this obvious truth is at least a positive attitude. For a patient to recognize that it indeed could have been worse is an attempt to harness new-found positive thought . . . "Wow. I sure am lucky! It could have been a lot worse." — Yet the realization of this point is not vital to his rehabilitation. What is important is that the professional staff, especially physicians, recognize the patient's genuine effort to sustain optimism, and gently direct this optimism toward the future. For example, "Yes, indeed, you are lucky! Your positive attitude will speed your recovery and will be invaluable to your efforts in physical therapy," etc. If the patient permanently adopts the attitude that "I sure am lucky," there is no harm done. The important consideration is of a positive attitude as applied to the future.

Associated with the clumsy recognition of a patient's handicap is the novice's tendency to want to help

— to try to do everything for the patient. The natural reaction only reinforces the patient's realization that he is a novelty, that he is different, that he is helpless. So then, the astute companion would be advised of the patient's self-respect and the importance of building in him an attitude of personal worth. The guideline is: Do whatever makes the patient feel most comfortable, least awkward. The following example will illustrate my point.

Jeff and I, being in adjacent beds, often entertained ourselves by playing chess. Jeff, although paralyzed from the neck down, has partial control of his shoulders and upper arms. (His forearms and hands are nonfunctional). Consequently, Jeff manipulated pieces by pushing them across the board, and removed captured pieces by sliding them onto the table. Occasionally he would struggle to right pieces accidentally knocked over, but was satisfied when he had the piece back in position. When it looked doubtful that Jeff could pick up a fallen piece, it was quite natural that I should set it right. Jeff did what he was capable of without unwanted help, but the impossible frustrations were prevented. Impossible tasks create unnecessary and pointless frustration for the patient, yet constant hovering crumbles feelings of personal worth, and prevents maximum rehabilitation.

To maintain the positive attitude so painstakingly developed by the hospital personnel, it is imperative that the physician counsels the family on the emotional as well as the physical care of the patient. The unwitting, though concerned family can easily destroy what the staff has so carefully developed.

The following edited passage from Wilfrid Noyce's *They Survived* introduces an associated facet of patient care:

Surround yourself with affection . . . The orphans and aliens, those who belong to nobody . . . their struggle is ten times grimmer. The presence of a wife, her humoring, even when forced, gives confidence that she expects you to live, therefore you must, in order not to disappoint . . . In order to survive any serious illness, what the patient needs is a sense of cheerful affection around, of optimism. . . A sick man's insecurity is bolstered by the assurance that everything will be all right, his self-respect propped up by the loving interest of others.[6]

The above words of a hospitalized terminal cancer patient apply universally. All patients need a "sense of cheerful affection." In my own case the loving and steadfast support given by my selfless family, wife, and close friends buoyed my spirit throughout my two-year ordeal. The hospital patient who is alone depends on other patients, nurses' individual care, and services of the hospital to fill the gap.

The regimentation forced by hospital life should be relaxed as much as possible. Many patients enjoy the luxury of sleeping until breakfast, and appreciate the nurse who enters quietly for 7:00 a.m. temperatures and just pokes the thermometer gently into their mouths. Compare this with the nurse who strides into the room, flips on the lights, yodels good morning, and broadcasts the 7:00 a.m. news and weather report; or the nurse who drops a cold, wet wash cloth into the patient's sleepy hand and asks if he wouldn't like to wash up before breakfast. — No, he wouldn't like to wash up before breakfast. — As a matter of fact, he would like to sleep until 1:30 in the afternoon!

There are a few common courtesies often transgressed. As with the cold wash cloth, patients resent being awakened by a noisy change of the night and day shifts at 6:45 a.m. This unnecessary noise reflects a lack of courtesy and further intrudes on the patients' privacy.

Perhaps the most offensive invasion of privacy is the prying hand and staring face that ignores the curtain drawn around the bed for 20 minutes in the morning. During this brief interval the patient attends to personal hygiene, sponge bath and bedpan. This flimsy privacy is often all the patient has in his otherwise scrutinized existence. Even though

the curtain is drawn, it is daily ignored by those who rap on the wall, but stand impatiently expecting entry, or just barge in. It seems that the ice water woman, wastebasket woman, and the menu delivery woman have all planned their schedules to crumble the remains of the patient's few moments of privacy.

I was incensed by this constant invasion. However, as a patient confined to bed, I doubted the wisdom of offending those upon whom I depended for care. So now, armed with my pen, I direct the following request to the responsible parties: Please adjust the schedules of the ward personnel. It should be pointed out that these people are employed to provide service to the patient, not to destroy his peace of mind.

Unquestionably the most destructive and least easily tolerated failing is the slow response to pain-medication requests. Pain is very real and often urgent. When the patient calls for medication, he finds it difficult to interpret the slow response as anything other than lack of concern. I have suffered the agony of unheeded response to requests for such medications and upon studying the problem have reached the following conclusions: 1. This suffering is needless; there are floors where a call light brings a nurse who then fills the prescription personally. 2. On the floors where response is slower (often on the order of 25 to 40 minutes) the problem is not so much a lack of compassion as inflexible routine.

The following is a summary of my study of inflexible routine re-

garding the dispensing of medications. Except for screams, blood, or tears, requests for medications relief are usually answered, "I'll tell the medications nurse." The patient calls again thinking the first call light has been forgotten. "Yes, Mr. Jones, the medications nurse is on the way." Nothing. A third call in desperation brings results: The medications nurse.

I failed to understand how the medications nurse could be "right on the way" for half an hour, until I was on crutches and could examine the problem. The nurse was wheeling her medications cart down the corridor one room at a time, dispensing her medications: sleeping pills, vitamin pills, sugar pills, Carter's Little Liver Pills. The patient experiencing stabbing pain finds it unreasonable that his requests should not take priority over the nurses' schedule of routine dispensation. Thus, I direct the following request to pain medications nurses everywhere: Please park your cart for 30 seconds and give Mr. Jones his needed injection of demerol.

A few words of defense for our sweet nurses are necessary. There are patients who habitually pull their call light one and a half hours before they are permitted more pain medication. The nurse answering the call light of weak-kneed Mr. Maxwell should explain that his prescription is for every three hours, and suggest that he talk to his doctor. My request is on behalf of the patient who awakens in the morning knotted in pain only to find the medications nurse is at the other end of the cruel corridor.

My last criticism is directed to hospital administrators. It is difficult to know exactly to whom I should address my complaint. It seems that the chain of command is so unwieldy that everybody offers regrets, condolences, and shrugs, "It's just one of those things," or announces that "things are done for a purpose" and that "they've worked well for fifty years, thank you." I am baffled by the lack of coordination and the senseless competition between different services, different departments, and different buildings of the same hospital complex. These little battles are fought at the patient's expense. Although I will describe only a few, the examples are endless.

Mr. Caesar's son, Joe, was admitted to the hospital one weekend, requiring complicated surgery for his crushed hip. A special power drill was necessary for this pressing, but not emergency operation. The neurosurgical team upstairs had such a drill and was not using it. The neurosurgical staff's reluctance to make this piece of equipment available caused a day-and-a-half delay.

I have experienced this same asinine adherence to tradition. I was to be fitted for a new body cast three weeks following surgery. I was wheeled to the cast room of my hospital building, and was amazed that such a primitive plaster table was going to be used. Instead of the usual supports, overhead frame work, and adjustable stirrups, this plaster table was exactly that, a table. My leg was held out at an angle over the floor by an orderly. I was nervous that a slip or a twist by the orderly would result in disaster.

I did not verbalize my concern at the time but later inquired why such a seemingly modern hospital continued to use such a flimsy table. I was told that the adjacent building of the same hospital complex did have a modern table. I asked why the modern table was not used. "Oh no, couldn't do that, the modern table belongs to the so and so building." Dumbfounded, I researched the situation, and found that such incongruities are common. Everyone mumbles phrases about "modern facilities and patient care," "human suffering and medical science." Yet, the world of white coats and stethoscopes is drowning in a sea of unreasoning tradition.

One last example that truly amazed me was the discovery of the pecking order among practicing physicians. Certain special privileges and priorities are given to men with prestigious titles. My specific example, although I'm sure others are abundant, regards the reservation of operating room time. Schedules are made after considering what doctors, what names, and what reputations are involved. A patient tentatively scheduled for pressing Monday morning surgery can be bumped by a big name staff surgeon who decides to handle a series of elective surgical cases Monday morning. If the afternoon operating time has already been reserved for another equally impressive name, our poor patient is forced to vegetate in agony while our heroes of medical science perform their mystic rites. The disbelieving reader will be comforted by the knowledge that all emergency and deathbed cases are given priority over men of distinction.

Summary

In conclusion, the care of the hospital patient is much more than treating disease. Comprehensive medical care involves the educated interaction of physicians, nursing staff, and non-professional hospital personnel. To realize maximum treatment, adjustment, and recovery, the progressive clinic must prepare itself to handle all aspects of a patient's health — physical, mental, and social.

FOOTNOTES

1. Knowles, John H. *Massachusetts General Hospital: A Brief Review, 1967*. Report of the General Director, Boston, Mass., 1967, p. 3.
2. Ibid.
3. Suppositories were given to paralyzed patients otherwise unable to move their bowels.
4. The halo is a device that applies traction to the neck vertebrae. This apparatus consists of a body cast (torso) that anchors a framework extending above the head. The framework supports a steel band around the skull. The band is anchored to the skull with five or six screws. Tension is applied to the neck by adjusting bolts on the framework of the halo.
5. Knowles, *A Brief Review*, p. 7.
6. Noyce, Wilfred. *They Survived: A Study of the Will to Live*. New York: E.P. Dutton Co., Inc., 1963, pp. 51, 53.

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HMS 1970

1920 Charles C. Lund

The more mobile members of HMS '20 were cordially greeted by our classmate Dorothy Murphy and her staff in the Faculty Room on Alumni Day 1970. Armed with cards and flowers we proceeded to the lawn where we began our education in what the devil has happened at the School by hearing from our alumni officers, selected deans, and a student. We gathered for lunch under the tent, then the alumni split up into three symposia to learn more in the afternoon.

Our main social event was a dinner in the Aesculapian Room at the Harvard Club. Dinner was provided through the kindness of the Alumni Association; champagne, through the courtesy of the Class of '45; and further education by Dean Robert H. Ebert who came to our dinner with Mrs. Ebert. We learned that the students, the faculty and the Establishment (to use a tarnished word) are in the process of marching together to greater achievements by paying more attention to people who have troubles than only to patients that have medical troubles.

Following Dr. Ebert's talk there was a leisurely question period. Some of us found this nostalgic as we heard each other handle this brand new subject with the same intonations and similar types of questions that we well remembered after 50 years. We also came away quite sure that Dr. Ebert's handling of the somewhat explosive situations of the winter and spring, with the help of the wise members of the faculty, and similarly wise students, will lead to constructive changes that will keep our School in the forefront.

On Saturday morning, the Class Day exercises, conducted by the graduating class, were most impressive. We have graduated a group of young doctors equal to or surpassing the best of any previous class. A closing luncheon was held in the luxurious Minot Room of the Countway Library. Altogether, 18 of the 42 classmates showed up. One of these, Howard Anderson of Salt Lake City, was present for the first time since 1920. Seventeen members and 14 wives came to dinner and 13 members with 8 wives to the final luncheon. Several classmates suggested that we meet again soon. Such a meeting has not been part of the official Alumni Association planning, but any classmates who want to do something new will only be following the lead of our current lively young graduates who are following our 50-year-old prehistoric footsteps by stepping further and faster than we did.

We wish to thank Dean Ebert, Lang Parsons and Dorothy Murphy who did all the hard work and made such fine arrangements.

Class of 1920

1925 Henry W. Hudson, Jr.

Twenty-eight classmates, 18 wives, one son, and three guests (on Saturday) were present for our 45th reunion. Nearly all the men and most of the ladies attended the morning and afternoon sessions of Alumni Day as well as the luncheon in the Quadrangle.

In the evening we assembled, most of us for the first time, at the Children's Inn for a social hour and dinner. Our speaker was Perry J. Culver '41 who told us of the selection process for admission and some of the problems of student financing. Both Dorothy Murphy and Lang Parsons were present for the social hour. All of us regret that both are now in their last year of service to the Alumni Association and all wish that some means of extending this service may be found.

On Saturday afternoon we assembled at the Duxbury home (circa 1810) of Jim and Jo Baty. Following a social interlude we enjoyed a delicious lobster bake. Later, as a group, we visited the lovely gardens of Mr. and Mrs. Richard Patrick where hundreds of azaleas, rhododendrons, and other flowering trees and shrubs produced a spectacularly beautiful sight and were a delight to the photographers among us.

Shortly after four o'clock the bus returned most of the class to the Children's Inn, but a few remained to visit and admire the Baty's grounds. We all are indebted to Jo and Jim and to the Patricks.

Unfortunately neither President George Saunders nor Secretary Bill Wishard could be present but our treasurer, Bob Linton, reported that the class is solvent.

REUNIONS

1930 Alfred O. Ludwig

Sixty-three members of the Class of 1930 registered for their fortieth reunion on May 29 and 30, 1970. Including wives, 90 were present on Alumni Day and 104 attended the dinner at the Harvard Club.

The Reunion festivities reached their peak on May 30th, when 78 were guests at the Babson's in Annisquam, and enjoyed their gracious and generous hospitality. Fred and Betsy Breed '43B and Larry and Magre Ross '41 provided a pleasant sail for a large group.

Afternoon and evening entertainment was furnished by the musical talents of Tom Babson, Hammy Hamilton and his one man orchestra, and the accomplished vocal accompaniments of Tom Anglem. The presence of Lang Parsons and Dotty Murphy, who joined us for several hours, a marvelous clam and lobster bake, and more socialization, completed a memorable day.

1935 Lamar Soutter

Of our 114 living members, 34 attended one or more events of our 35th reunion, most of them accompanied by their wives. The program on Friday was excellent and well attended. The business meeting on Friday afternoon was interrupted by an attempt to get the Alumni Association, as represented by the members then assembled, to notify the President as favoring immediate withdrawal from Vietnam. The debate was vigorously contested on both sides. A final vote came out with a clear majority not in favor of the motion. This delayed the afternoon program, which then proceeded with discussion in small groups about how the School should participate in a variety of activities.

The informal evening program took place in the penthouse on top of the University Health Center in Cambridge, which has considerable charm and an excellent view. During the cocktail hour, we were fortunate in being joined by Dean and Mrs. Ebert who talked with a number of members and their wives.

At the end of the meal, Dr. Joseph Gardella, associate dean for student affairs, gave an outstanding presentation on student attitudes, thought and behavior. For those out of touch with the present-day HMS student, this was very informative. Dr. Gardella's method of handling students, which seemed to most of us an extraordinarily intelligent blend of firmness and permissiveness, was discussed at some length after his talk, with a few expressing somewhat contrary convictions.

On Saturday afternoon a bus took those staying in Boston to Bitsy and Gordon Donaldson's house in Lincoln. There, a variety of activities took place, from visiting an art museum to athletic events. Boiled lobsters, steamed clams and corn were available on the grounds and consumed in a tent after the blood alcohol levels had been brought up to normal. One of the highlights of the evening was a visit by Dorothy Murphy and Langdon Parsons. The Donaldson's house and grounds were lovely and bucolic, complete with hens and horses. The latter, our research department found out, were not partial to lobster. The two days were clear and beautiful, but cold. Saturday night was a time for many individual conversations and reminiscences. It capped a very pleasant reunion and made it one of our best.

1940 J. Gordon Scannell

Thirty-three members of the Class of 1940, mostly with wives accompanying them, returned for our 30th reunion. Our most distal representatives were Jim Thompson and his wife, who, coming from California, were once again given the opportunity to see what New England weather can really be like if it tries.

Alumni Day went well indeed. One of our members, Tom Hunter, led off the panel of deans in the morning session, leaving us suitably aware of the winds of change that are blowing; and once again we were made conscious of what an articulate spokesman we had.

Many of the class had accommodations at the Somerset Hotel, and they joined the local contingent for a dinner dance on Friday evening at the Wellesley Country Club, the scene of our senior dance in 1940. It was striking, as the evening wore on, how rapidly the actors and the scene reverted to those halcyon days. Suddenly, about 11:30, large orange coaches appeared in true Cinderella fashion, and transported the happy throng, with their extracellular fluid space well expanded, back to their lodgings.

Many came back to Class Day exercises and were reassured by the solidity and promise of the graduating class, remaining calm but committed through change and through storm.

The afternoon found us suitably attired at the Gepharts where Sally and Tom generously hosted our clambake, which arrived on wheels from Gloucester, as the shadows were growing longer and the glasses emptier. By this time, with great care, only the lobsters and clams were baked. No members found their way beneath the tent though by that time the New England spring had reverted somewhat to its arctic heritage. As the shadows grew longer, the class congregated in the house and, with song and cheer, struggled bravely with the lobsters and clams, and won.

Special thanks, of course, go to Dean Murphy and also to our classmate, Bob Arnot, who not only arranged the reunion, but with a sure and gentle hand, kept the spirit moving well.

Class of 1945

1945 Warren W. Point, 3d

Uncertainty was the mood as the Class of 1945 approached its 25th reunion. We were uncertain if there would be a traditional celebration, uncertain if recent national events would permit an assemblage of our classmates from near and far. The sun shown upon us, the ceremonies were peaceful, and a great many members of the Class did turn up. None made it from outside the continental United States, but we did receive their good wishes. Our format was very traditional with dinner at the Harvard Club presided over by our perpetual president, Ike Taylor, and featuring Dean Ebert. Drs. Mark Altschule, George Thorn, and Langdon Parsons also starred, reminding us of those innocent days of long ago.

Friday morning all of the Reunion Classes joined to hear Ike and a distinguished panel discuss medical school governance. We then presented to the Dean a sizeable class gift of $62,782.69, representing an accumulation of gifts since 1951. Following a delicious luncheon there was heated discussion at the Alumni Business Meeting concerning a resolution to place the alumni meeting on record as opposed to the current Indo-China policy. This was voted down as inappropriate.

Friday night we adjourned to the Country Club for a well-attended dinner dance; Dottie Murphy was a welcome addition as was Lang Parsons. Dick Thaler recited a new series of inimitable class poems; then Harry Hinckley formed a group to recite the Saga of Fairbanks the Cat and a plea to "Leave My WAC Alone." Nearly all of the New England contingent appeared, plus Royce, Morrell, Harvey, Bunker, and Goldsmith, all from California, Tex Cobb from Dallas, Jack Carey from Oklahoma, and a sprinkling from all parts of the nation. Barney Zimmerman made his first reunion in 25 years and said he could not wait for the 50th.

A hardy residue reassembled at Ipswich Saturday afternoon for the native clams, lobster, and beer. It was a fine ending for our 25th.

1950 Donald S. Gair

A quorum of the Class of '50 celebrated our twentieth reunion this year and had a very happy time. Our Dinner Dance was held at the old Copley Plaza. Professors Mark D. Altshule '32 and T. Barton Quigley '33 honored us with their presence but reneged on a soft-shoe routine claiming they needed Chancellor J. Englebert Dunphy '33, who could not attend. In fairness, they more than atoned with their erudite and enlightening remarks, which even broke up the usually stone-faced backdrop of six Ruby Newman musicians and a head waiter.

Highlight of the dinner was the presentation of the Last-But-Not-Least award to Evelyn Davis Waitzkin who was in the final weeks of what is believed to be the ultimate residency training in the Class. HMS '50 was thereby spared the beginning of its middle age until 1 July 1970.

On Saturday we went to the Essex County Club where many classmates displayed Wimbleton form before taking to the courts while others humbled the fabled Essex County links. (Richard Lundy Butler, Brynner-headed and with sly ambidexterity beat me at tennis, 6-2, 6-2.) The unfair distribution of paunches was at least transiently equalized after a truckload of lobsters, clams, and fixings vanished down the collective maw. As a digestive aid, faithful renditions of the Australian Marching Song and other sentimental favorites were belted out lustily. It seemed too short a time together. Everybody was glad to see everybody else.

Those who did not come were missed. Some chose not to come believing that the desperate troubles in the world at this time made it inappropriate to have the traditional festivities. Those who came, for the most part, felt that the happy tradition was more than ever indicated. There can be no disagreement about everyone's wish that by the time of our twenty-fifth everyone can be together.

Dorothy Murphy and her staff outdid themselves with the arrangements.

1955 Roman W. DeSanctis

A relatively small but enthusiastic group from the Class of '55 gathered for this celebration of the achievement of medical adolescence. The Alumni Day exercises at the quadrangle reflected for the most part the chaos and uncertainty of the times and the struggle of students, administrators, and alumni to communicate. Those in attendance found the program quite interesting.

On Friday evening a dinner dance was held at the roof of the State Street Bank Building, one of Bos-

ton's new downtown skyscrapers. Blessed with an unusually fine evening and a magnificent view, the 37 members of the Class of '55 and their wives who gathered there had a delightful time. Highlight of the evening as usual was Mitch Rabkin's treasurer's report. Mitch has defied all advice to the contrary and kept the Class funds in a savings bank, where, at 5% interest per year, our Class is considerably ahead of a lot of other investors nowadays! Al and Nancy Heising from San Diego and Larry Dietlein from Houston won champagne for coming the longest distance.

The outing on Saturday was held at the Emerson Inn at Pigeon Cove in Rockport. It was a beautiful, if somewhat chilly, day, but the beer made it more tolerable and the lobster bake was a gustatory delight.

The 15th reunion is over, but the memories of the pleasure derived from seeing old friends linger on. The Reunion Committee wishes to express a special word of thanks to Dottie Murphy in the Alumni Office, who has always provided such great help in planning the occasions. We all look forward to the next reunion five years hence.

1960 Robert L. Shirley

With Dick Kingsbury's new 10th reunion red book in hand, the 1960 members enjoyed the recent return to campus with approximately 60 classmates. Except for the distinguished grey hair of internists Bernier and Norden, and the Sirgay Sanger svelte silhouette, the decade has changed our collective appearance little. Of course, some obligatory alopecia and beam-broadening has crept along.

The official program of Alumni Day and much of the person-to-person chatting revolved about the fact that medical student teaching is becoming a more exciting and challenging endeavor each semester. The problems of budget-dwindles and curriculum expansion seemed to be sublimated by the social, racial, and international issues emphasized by the very vocal "new medical student."

During the annual business meeting of the Association a "pull out of the war proposal" escaped being tabled by a 95 to 100 vote. It was voted down, 122-73, after a moderate discussion. Interesting was the absence of the previously critical student activists from the Friday afternoon seminar concerning the School's community responsibilities, which was arranged at their request. Apparently the administration representatives welcomed a chance to meet their *banderilleros* in calm, open discussion. The students' boycott went unexplained.

The social events were arranged by the one and only Dorothy Murphy. Friday night's dinner at the Hotel Sonesta was delicious and well attended. Saturday's clambake at Sagamore Beach was blessed with bright sunny, if breezy, weather. Marshall Kaplan countered the only crisis with a gallant foray into the countryside on a beer search.

We hope that the barber strike in Los Angeles is soon ended.

1965 William D. Clark, 2d

In proper reunion tradition, some 30 classmates and their wives "partied it up" during Alumni and Class Day festivities. We kicked off with cocktails at the Countway and then continued to dinner at diverse eating spots around town.

On cool and sunny Saturday we played games and feasted at the Earle Chapmans' in Brookline. Over beer and lobsters the questions of the day were:

How many kids so far?

What are you doing from now on?

When did you grow all that hair?

Most were fairly definite about answers to the first and third queries, but that second one still causes trouble for many of us. Somehow we cannot keep all the options open by staying in training programs forever, and we expect many more definite commitments made by our tenth.

EDITORIALS

"Crabbed Age and Youth"

The Council of the Alumni Association met at the Harvard Club during the afternoon of Thursday, May 28, with President Faulkner in the chair. The names of the nominees for officers and councillors were presented — F. Sargent Cheever '36, for president; Maxwell Finland '26, for president-elect; and Carl W. Walter '32, for treasurer. William R. Pitts '33 was nominated as representative to the Associated Harvard Alumni. All were approved the following day at the annual meeting, as were John W. Littlefield '47, Samuel L. Katz '52, and W. Gerald Austen '55 for the Council. George S. Richardson '46 has agreed to expand his duties as a member of the editorial board of the *Bulletin* by assuming also those of deputy editor.

Dr. Parsons's report on the Alumni Fund showed that, despite an increased effort that had been urged on the class agents, the alumni have not been responding as well as had been hoped. So far 600 fewer subscribers have contributed $176,000 or $20,000 less than at the same time a year ago. The decline was attributed to the general economic situation and the nationwide student unrest that has adversely affected the generosity of alumni, here and elsewhere. Since the important purpose of the Fund is to provide undergraduate scholarships, the loss may be seriously felt. However, as the *Bulletin* goes to press an improvement is being noted.

An important feature of the Council meeting was a discussion with Lloyd Axelrod '67, who had been invited to report on behalf of a "strike steering committee," elected early in the month at a mass meeting representing several hundred employees, students, faculty members and administrators of the School. Dr. Axelrod's immediate purpose was to request the Council to permit a representative of the strike committee to address the annual meeting of the Association on the following day to acquaint it with five "demands" that the committee was promulgating and for which it desired the Association's support.

At the Friday meeting these demands were presented by David Spiegel '71 as follows:

1. That the United States government cease its escalation of the Vietnam War into Cambodia and Laos; that it unilaterally and immediately withdraw all forces from Southeast Asia.
2. That the United States government ends its systematic oppression of political dissidents and release all political prisoners from such groups as the Black Panthers, Young Lords, Patriots, Student Nonviolent Coordinating Committee, and others who speak out against war and racism.
3. That the universities immediately end defense research, ROTC, and counter-insurgency research, and all other such programs.
4. We condemn the murder of students by the National Guard at Kent State University, and also condemn the clear-cut Presidential policy of intimidation and of prevention of expression of constitutionally guaranteed rights to assemble and dissent.
5. The fifth demand in summary states the group's determination to strike in support of the previous four demands, asks that there be no reprisals against members of the strike, and asks President Pusey to express our condemnation of the Cambodian invasion to [President] Nixon.

During the annual business meeting, Victor W. Sidel '57 introduced the following resolution:

We, the majority of the members of the Harvard Medical School Alumni Association present at the annual meeting in Boston on May 29, 1970, condemn the continuing United States involvement in Indochina because of its destructive effects both on the people of Indochina and on the health and well being of the people of the United States. We urge the Congress promptly to limit United States involvement, we urge prompt disengagement and withdrawal of American troops, and we urge the redirection of national resources toward meeting the crisis in health care and other domestic problems.

After much debate and the rejection of a motion to table, the resolution was defeated, not because of a lack of sympathy with the proposal but because of a belief that approval of such a measure would be interpreted by many persons as an official endorsement of the resolution by the Association, with thousands of its members absent and unable to express themselves. It would be a sounder policy to urge the alumni to express their personal opinions individually.

Good manners, although unpopular in sundry segments of society, have not lost their intrinsic value, and the courteous behavior of our own undergraduates on this occasion rates more than passing mention.

We hear much, in these tumultuous times, of "demands" being made on conservative institutions by those who disagree with their methods, their actions, their decisions and even their principles, and are united in the attempt to change them as rapidly as possible. "Demands" in this sense is defined by Webster as implying "peremptoriness and insistence and often the right to make requests that are to be regarded as commands."

At its best the word as used is impudent and connotes intentional arrogance. Since it is often employed by those who seem not to know that a sledge hammer is an unnecessarily heavy instrument with which to drive a point home, the word suggests a threat rather than an attempt to communicate in a spirit of reasonableness. Further to ensure noncompliance the term "non-negotiable" is added as a gratuitous of-

fense; it can only be taken to mean that any meeting of the minds must be in the nature of a confrontation intended only to result in the surrender of the confronted party.

Every dissenting group, regardless of its intellectual level, is likely to contain its radical elements, seeking only to destroy that which they cannot replace, but in general the Harvard Medical students have shown themselves to be sincerely concerned, reasonable, and cooperative, and deserving of the Association's support. They are all, of course, soon to become members of the Association at varying academic intervals, with the privilege of helping to assume some of its responsibilities. It is important to realize that crabbed age and youth, Shakespeare to the contrary notwithstanding, can indeed live together and work together for a common goal.

"To Him That Overcometh"

Even as looking through the distal end of a field glass has the effect of shrinking the object toward which it is directed, applying the ear to the other end of the stethoscope may acquaint the listener with information that is all the more valuable because sometimes unexpected. This is the message that Hardin C. Jones, a member of the Class of 1973, has to offer in his essay, "The Other End of the Stethoscope," published in this issue of the *Bulletin*.

Already accepted for admission to Harvard Medical School three years ago, Hardin nearly lost his life that spring in a motorcycle accident. As he lay in hospital in San Francisco for a full year, he became intimately acquainted with the failings as well as the successes of modern medicine and surgery and of the administration of modern hospitals. He has told of his experiences as he found them, from the point of view of a patient especially interested in the practice of a profession that he still planned and hoped to enter. And now, still on crutches, still undergoing corrective surgery, still refraining from harsh criticism, he has funded a knowledge of the difficulties inherent in the healing art that has kept him from joining that small percentage of those who have selected medicine as a career but still seem unable to forgive its imperfections.

Having become practiced in overcoming obstacles he has perchance found comfort in Revelations 2.17: To him that overcometh will I give to eat of the hidden manna.

'Air Pollution

A report received from the Public Relations Department of the Children's Hospital Medical Center as recently as mid-January announced that "hair taken from the heads of the Apollo 12 astronauts is being analyzed by researchers of the Children's Hospital Medical Center who hope to develop a new method of determining the body's calcium loss during space flight." In view of the known fact that the body loses calcium during inactivity, it is intimated that the crew must have suffered in this respect, although their backbones were certainly not affected.

The part that hair or the lack of it has long played in human welfare is legend, and is currently becoming increasingly important, for it is apparent that among young men and women in particular hair has resumed its place as a status symbol, a conclusion that is illustrated by the experience of the young cockney who was taking his girl for a row on the Thames. Embarrassed when he rolled up his sleeves she tittered "A bit airy, ain't it?" referring to the slight breeze that was ruffling the surface of the water. "Wot did you expect" he retorted, thinking she referred to his 'airy forearm, "ostrich feathers?"

The therapeutic nature of "the hair of the dog that bit you" has long been recognized and assiduously applied, and everyone knows what happened to Samson on being shorn by Delilah. Prior to this tonsorial treachery he had slain 1000 Philistines with the jawbone of a single ass, and it was not until his locks had grown again that, although blinded, he was able to give them their come uppance by tearing the pillars from the house in which they had assembled.

Hair, in its relevance to nudity on the stage, has been a topic of debate in recent weeks in Boston, a town where the stock of the Puritans still lingers.

Kudos

One hears much these days, especially at Harvard Medical School, about the lack of good teaching. Students bemoan the amount of poor presentation they must endure; curriculum committees assert the necessity of teaching the teachers to teach.

Members of the Boylston Society this year decided to bestow special honor upon a member of the faculty who "demonstrates devotion and excellence in teaching." The first Boylston Medical Society Faculty Award was presented to Dr. Harvey Goldman, assistant professor of pathology.

Dr. Goldman has achieved extraordinary popularity through his interest and ability in the teaching of pathophysiology to students during their first two years. When armed with Carousel projector and tray of pathology slides, he is unsurpassed in the delivery of delightfully stimulating and informal teaching sessions.

Dr. Paul S. Russell, outgoing president of the Society, expressed the hope that this award, which will be given annually, will mark the beginning of a period during which closer relations will develop between students and teachers at HMS.

PROMOTIONS AND APPOINTMENTS

PROFESSOR

John R. Brooks '43B: surgery at Peter Bent Brigham Hospital
George F. Cahill, Jr.: medicine
Albert H. Coons '37: bacteriology and immunology
Kendall Emerson, Jr. '33: medicine at PBBH
C. Miller Fisher: neurology at Massachusetts General Hospital
Park S. Gerald: pediatrics
Leston L. Havens: psychiatry at Massachusetts Mental Health Center
Samuel Hellman: radiation therapy
Ernst Knobil: physiology
Myron B. Laver: anesthesia
William C. Moloney: medicine at PBBH
William W. Montgomery: otolaryngology at Massachusetts Eye and Ear Infirmary
Julius B. Richmond: child psychiatry and human development
Somers H. Sturgis '31: gynecology at PBBH
Armen H. Tashjian, Jr. '57: pharmacology in the School of Dental Medicine

CLINICAL PROFESSOR

Henry M. Fox: psychiatry

ASSOCIATE PROFESSOR

Leonard Atkins: pathology at MGH
John F. Burke '51: surgery
James B. Caulfield: pathology at MGH
Joseph M. Corson:pathology at PBBH
Chilton Crane '38: surgery at PBBH
Stanley H. Eldred: psychiatry at McLean Hospital
David S. Feingold '58: medicine
Robert M. Filler: surgery at The Children's Hospital
Daniel H. Funkenstein: psychiatry at MMHC
Richard R. Gacek: otolaryngology at MEEI
Thomas J. Gill, 3d '57: pathology
Helen H. Hess '51: neuropathology
Daniel V. Kimberg: medicine
Jerome O. Klein: pediatrics at Boston City Hospital
Martin B. Levene: radiation therapy at Joint Center for Radiation Therapy
Charles P. Lyman: anatomy
Vernon H. Mark: surgery at BCH
Benedict F. Massell '31: pediatrics at TCH
Janet W. McArthur: obstetrics and gynecology at MGH
Elliot G. Mishler: psychology in the department of psychiatry at MMHC
Donald K. Morest: anatomy
Philip J. Porter: pediatrics at MGH
Stephen H. Robinson '58: medicine
Fred S. Rosen: pediatrics
Sanford I. Roth '56: pathology
Bernardo A. G. Santamarina: obstetrics and gynecology at BCH
Joseph J. Schildkraut '59: psychiatry at MMHC
Herbert A. Selenkow: medicine at PBBH
Richard I. Shader: psychiatry at MMHC
Stephen M. Shea: pathology
Edward A. Sweeney: pediatric dentistry
Gordon F. Vawter: pathology at TCH
D. Michael Young: biological chemistry in the department of medicine

ASSOCIATE CLINICAL PROFESSOR

Mark D. Altschule '33: medicine
Douglas A. Atwood '46: prosthetic dentistry
Jack R. Dreyfuss: radiology
Sanford I. Gifford, Jr.: psychiatry
Robert L. Glass: ecological dentistry
Krishan K. Kapur: prosthetic dentistry
Philip M. Lecompte: pathology
Simeon Locke: neurology
George L. Nardi: surgery
Leonard T. Swanson: pediatric dentistry
Peter K. J. Yen: orthodontics

ASSISTANT PROFESSOR

David S. Auld: biological chemistry
Robert B. Berg '52: pediatrics at Beth Israel Hospital
Norman R. Bernstein: psychiatry at MGH
Robert S. Blacklow '59: medicine at PBBH
Robert L. Bragg: psychiatry at MGH
John G. Clark, Jr. '53: psychiatry at MGH
John T. Chaffey: radiation therapy
David E. Drum '58: radiology
R. Curtis Ellison: pediatrics at TCH
Richard I. Feinbloom: pediatrics at TCH
Pierce Gardner: medicine
Generoso G. Gascon: neurology at TCH
Bennie Geffin: anesthesia at MGH
Lowell A. Goldsmith: dermatology

Max L. Goodman: pathology at MEEI
Herman A. Godwin, Jr.: medicine
Jon E. Gudeman '63: psychiatry at MMHC
Edward D. Harris, Jr. '62: medicine
Harley A. Haynes '63: dermatology
Elizabeth T. Hedley-Whyte: neuropathology
Howard T. Hermann: psychiatry at McLH
David J. Ingle: psychology in the department of psychiatry
Yuet Y. Kan: pediatrics
Ellen S. S. S. Kang: pediatrics at TCH
Paul S. Levy: preventive medicine
Ann M. Lewicki: radiology at PBBH
Abraham Marck: radiation therapy at JCRT
Phillip S. Marcus: anesthesia at BCH
Kilmer S. McCully '59: pathology
James M. McNeill: radiology at MGH
Ezio Merler: bacteriology and immunology at TCH
Lewis C. Mokrasch: biological chemistry at McLH
Kiyokazu J. Momose: radiology at MGH
Benjamin J. Murawski: psychology in the department of psychiatry at PBBH
Stanley E. Order: radiation therapy
Michael N. Oxman '63: bacteriology and immunology at TCH
Johanna A. Palotta: medicine at BIH
Ernest H. Picard '55: neurology at MGH
Louis F. Plzak, Jr.: surgery at TCH
David G. Porter: anatomy
Eric L. Radin '60: orthopedic surgery
Sidney V. Rieder: biological chemistry at MGH
Franz Rodriguez-Erdmann: medicine at PBBH
Seymour Rosen: pathology
Arthur E. Rosenbaum: radiology
Amnon Rosenthal: pediatrics at TCH
Paul M. G. St. Aubin: radiology at MGH
Carl Salzman: psychiatry at MMHC
Eveline E. Schneeberger: pathology
Christian Schwabe: biological chemistry in SDM
Herbert Silverstein: otolaryngology at MEEI
Edward H. Smith: radiology at PBBH
William B. Stason '60: medicine at BCH
Roy D. Strand: radiology at TCH
Jay M. Sullivan: medicine
Kotaro Suzuki: obstetrics and gynecology at BIH
Emil R. Unanue: pathology
Milton M. Weiser: medicine
Jess B. Weiss: anesthesia at Boston Hospital for Women
Nicholas T. Zervas: surgery at BIH

ASSISTANT CLINICAL PROFESSOR

Harry K. Bailey: operative dentistry
Lenore A. Boling: psychiatry
S. Arthur Boruchoff: ophthalmology
Robert J. Brockhurst '47: ophthalmology
Norman T. Budde: pediatric dentistry
Louis Burke: obstetrics and gynecology
Perry J. Culver '41: medicine
Max Day: psychiatry
Thomas L. Delorme: orthopedic surgery
Harold W. Demone, Jr.: social welfare in the department of psychiatry
Donald P. Dressler: surgery
Ralph P. Fèller: prosthetic dentistry
Eugene E. Fischer: prosthetic dentistry
Sabit Gabay: oral biology and pathophysiology
Vincent L. Genua: prosthetic dentistry
Joseph F. Gerstein: medicine
Ward I. Gregg '32: gynecology
John W. Grover '56: obstetrics and gynecology
E. Robert Haynes: operative dentistry
Earl E. Hellerstein: pathology
Arthur L. Herbst '59: obstetrics and gynecology
Louisa P. Howe: sociology in the department of psychiatry
B. Thomas Hutchinson '58: ophthalmology
Albert J. Kazis: dental auxiliary utilization and training
Richard Masters '53: dermatology.
Samuel L. Mogul '52: psychiatry
Edward A. Nalebuff: orthopedic surgery
Carter R. Rowe '33: orthopedic surgery
Walter T. St. Goar: medicine
Emile C. A. Samaha: prosthetic dentistry
S. Patric Scavotto: dental radiology
Alfred W. Scott '48: ophthalmology
Stephen Stone: periodontology
David Weintraub: obstetrics and gynecology
Harold A. Wilkinson: surgery
George H. Wyshak: dental auxiliary utilization and training

PRINCIPAL ASSOCIATE

Bruce Cushna: pediatrics (psychology)
Jozef K. Cywinski: anesthesia (biomedical engineering)
Michael A. Davis: radiology (nuclear medicine)
Madhukar A. Pathak: dermatology (biochemistry)

PRINCIPAL RESEARCH ASSOCIATE

Jean B. Burnett: dermatology (biological chemistry)
James W. Drysdale: surgery
Uel J. McMahan, 2d: neurobiology
Cedric Minkin: oral biology and pathophysiology
Luka Rabadjija: oral biology and pathophysiology
Dorothy B. Villee '55: pediatrics

LECTURER:

Wilfred Bloomberg '28: psychiatry
Francis L. A. de Marneffe: psychiatry
William B. Kannel: preventive medicine
Lawrence J. Kunz: bacteriology and immunology
Harry L. Mueller '34: pediatrics
Helen H. Tartakoff: psychiatry

Letters

Pro and Con Continued

To the Editor:

In reply to the letter of protest published in the March-April *Bulletin*, may I say that after the tragic events at Kent State, it is quite clear to this graduate of HMS that "enlightened and intelligent leadership" is precisely what Dean Ebert offered by "participating in a peace demonstration." (And where better than in downtown Boston — Walden Pond, perhaps?)

Making a stand for peace is certainly consistent with the aims and ideals of the thoughtful, compassionate physician. I am sure that Dean Ebert did so with far more maturity and restraint than is sometimes practiced by those who conduct our affairs, and whose examples do indeed incite the young to violence.

My congratulations to him and to those who demonstrated with him.

George C. Owen '31

To the Editor:

I have written two letters to the *Bulletin* in response to your "Moratorium" coverage in the November-December issue. One was written in a fit of anger and resentment, and you offered to publish this one. The other was longer, written in a calmer frame of mind and designed to show some of the constructive things Americans are doing in Vietnam. This was turned down because it was too long (it requires less length to criticize someone's work than it does to present the work of even a few people). If you choose to publish the first letter, as I have amended it below, do so, and let me explain to the readers that it is an example of the heartfelt resentment of one Vietnam veteran who, during his year's turn there, worked hard to help the Vietnamese people, using his skills as a doctor.

I will not be contributing to the Harvard Medical Alumni Association this year. My reason is contained on pages 22-23 of the November-December issue of the *Bulletin*. Whereas I dearly love Harvard Medical School, and support its efforts in such areas as increasing opportunities for minority group students, I cannot support the blatant and one-sided political viewpoint expressed on these pages. Some of us have been to Vietnam. I doubt that any of the people pictured on these pages have been there, or if they have, I doubt it amounted to any more than a sightseeing tour, where you can see whatever you want to see. Of those who have been to Vietnam, those who demonstrate against the war are the overwhelming minority.

Those of you too old to have been sent to Vietnam, and those of my own age group who spent a comfortable two years of service here in the States, have not seen village chiefs strung up by the arms and eviscerated. You have not taken care of innocent children with satchel charge fragments in their brains. You have not gone to villages looking for your sick patients, to learn that, because the V.C. took their children, the parents, including the mother with liver failure, went too, to serve as enforced porters. You have not seen the children injured by the fragments of a recoilless rifle round on their way home from schools. You have not witnessed the nurse at a Vietnamese dispensary who lost an arm and a leg when the V.C. fired on the dispensary. Nor, I might add, have you been given the liberty to do all in your power to save the life of a sick V.C. or N.V.A., while for days an American M.P. stands guard to make certain some unreasonable Vietnamese or G.I. will not kill the prisoner. Nor have you inspected a Vietnamese prisoner of war camp, talked to the V.C. doctor, been given the liberty to treat any sick prisoners and agreed to treat any patients the V.C. doctor wanted to send you. (He took us up on this offer more than once.)

The Alumni Association, through its *Bulletin*, has taken the side of the enemy. You cry out against atrocities committed by our side, but I hear not a word about the perpetrators of the atrocities I have personally witnessed. Your justice is one-sided. When you have a day of protest against the cruel men on the enemy's side who shoot at little children on their way home from school, and at village dispensaries, I will join you. This year, I could not have given much money anyway, but what I have will not go to organizations which support cruel men who will never be brought to justice.

W. Peter Peterson '63

book reviews

Introduction to the History of General Surgery by Richard H. Meade '21. 403 pages, illustrated. Philadelphia: W. B. Saunders, 1968. $17.00.

Dr. Meade presents his subject in a concise and refreshingly readable manner. He adopts a topical approach by breaking his material into special studies of different aspects or departments of surgery. Each of these separate headings is then treated with a consecutive review of its progress from start to finish. Here the author shows depth of knowledge combined with masterful powers of summation. Ancient surgical backgrounds have not been neglected, but the general reader today will be pleased to find that modern surgical advances have re-

ceived a full share of attention. For the benefit of the more specialized reader, extensive bibliographies have been supplied in the midst of the text where they are conveniently accessible. The articles are accompanied by excellent illustrations consisting largely of portraits which add much to the personal and human interest of the subject.

The author has tried to confine himself to general surgery; but in recent years, the specialties have branched out from the main stem like filaments of the cauda equina emerging from the spinal cord. It is impossible to determine just when a general surgeon's focalized interest turns into a specialty, or how far that specialized interest should be pursued. As far as he follows these specialties, the author has supplied a great amount of interesting material. However, when it comes to modern advances, some topics have had to be covered too superficially to seem adequate.

This book is highly recommended as a valuable reference for any doctor who wants to correlate surgical progress from ancient time down to modern practice. It more than lives up to its title as an introduction to the subject, and it supplies a concise, readable, well selected, and clearly presented text.

CHARLES H. BRADFORD '31

Symposium on Ghetto Medicine

Medicine in the Ghetto. Edited by John C. Norman '54. 333 pages. New York: Appleton-Century-Crofts, 1969. $6.95.

> "Health of mind and body is so fundamental to the good life that if we believe men have any personal rights at all as human beings, they have an absolute moral right to such a measure of good health as society, and society alone is able to give them."
>
> Aristotle 333 B.C.

During three days of June 1969 ". . . a group of approximately 200 people having a broad range of experience and personal commitment, and drawn from across the nation, met in Portsmouth, New Hampshire, to examine the present condition of health among ghetto dwellers, . . . and to consider possible future courses of action towards improvement." They met with the basic assumption that "good health is universally recognized as a basic right of all citizens, but in practice, millions of Americans are denied the full benefits of medical science because they are poor and because they are confined by social, economic, and cultural forces to isolation in the ghettos of our large urban centers." The result of these three days is a 333-page collection of speeches and discussions about the ills of our society, and about the distribution and dispensation of medical care within this society. It offers an informative, lively, one-sided, penetrating, condemning and oftentimes frightening perspective of the political, organizational, and individual components of today's "medical establishment."

The conference was jointly sponsored by Harvard Medical School, the *Boston Globe,* and the National Center for Health Services Research and Development. The participants represented a broad spectrum of experience (although certainly not of opinion) and most were eminently qualified to discuss their assigned topics. Most notably absent, however, were any loyal representatives of the traditional viewpoint, or anyone who felt there might be some positive aspects to the way medical care is currently dispensed in America. This bias is important in terms of the conclusions one draws after reading the book, but not in terms of the impact of the facts presented, or the emotion and sincerity of the participants involved. This is a potent book from which the uninvolved, who only read an occasional magazine report or newspaper, have much to learn.

Three basic concepts are developed throughout the book: 1) unequal medical care exists in the United States today; 2) the problems of poverty are multifaceted; and 3) one must be healthy to make a living and live a full life. One cannot help but be impressed with statistics such as: Negroes pay an average of 10-15 percent higher rents than whites for comparable housing; Negroes represent 11 percent of the enlisted personnel in Vietnam, but 22.4 percent of the troops killed in action; prior to 1969, there had never been more than three Negroes in any one Harvard Medical School class, virtually none had ever trained at any of the 18 affiliated teaching hospitals, and none has remained in Boston to practice; black infant mortality rate is three times that of the whites' in America (182/100,000 vs. 573/100,000). The black rate is largely attributable to prematurity, which many people feel reflects the poverty, malnutrition in mothers, maternal exposure to infection, and lack of prenatal care. This figure does not reflect the morbidity, brain damage, and mental retardation seen in those who survive.

If one is not impressed with facts and figures, one surely cannot help but be moved and most probably frightened by the emotional content of what was said. The conviction of the Negro speakers of the plight and prognosis of the ghetto people makes one realize that these men and their problems are not to be denied and cannot be ignored. At times there is a total lack of logic and emotion rules in the arguments which are put forth. (e.g. question — "How long will racism in medicine last?" — "America is a thoroughly racist society; and there is no indication that it will change very soon; organized medicine is an institution of the American society, therefore the future of racism in medicine is assured.") This lack of rationality is frightening, but at the same time, impressive in terms of

the emotion and apparent underlying frustration. Melvin H. King, executive director of the Urban League of Greater Boston, delivered a subjective, unsubstantiated, and in many ways incomplete diatribe on the suppression and unfair treatment of the Negro people; his logic may be lacking, but his conviction contains a message in and of itself.

Expectations of the people involved in current ghetto activism seem to be three in number: 1) local communities, whether they be ghettos or suburbs, should be made aware, and have a role in, the planning and instituting of programs that affect their communities; 2) the ghetto residents are more and more demanding some of the "capital" or "action" in their communities, and in essence are asking for more power; 3) it was generally felt that blacks, as workers, have been repressed and that they should be elevated to higher positions. Few facts or figures are offered to support the propriety of these demands, but a good discussion and historical perspective is put forth by Richard G. Hatcher, Mayor of Gary, Indiana.

Nathan Hare, chairman of the Black Studies Institute at San Francisco State College, makes a very eloquent argument for separatism in black and white medical care. This is a concept that most people will probably find very unappealing, but it represents the conclusions of an actively involved and well informed individual as to how one can eradicate the deficiencies of ghetto medical care. He presents arguments with which everyone should be acquainted.

Most of the panelists make some comment as to their outlook for the future. It is encouraging to note that they generally approach the problem of ghetto medicine and poverty in America optimistically. Traditional methods and institutions such as fee-for-service, medical schools, welfare, etc., are attacked vigorously, yet the potential for change was recognized. Lloyd C. Elam, president of Meharry Medical College, says "the health system has difficulty responding to the expectation of this sector of society for quality care because of the delusion of so many members of the health-care professions that we are already making significant progress in providing such care. We are not. What has been done in the past few months and years provided a few more resources, some demonstrations, and some changes in attitudes. But the job remaining is huge . . . There must be a rapid expansion on a vast scale, if the differences in standards of health for black and whites is to be eradicated and the levels of health of both raised."

"In August of 1965, the silent voice of despair became the agonized scream of a community that could no longer tolerate the injustice, the deprivation, the dehumanization, and the indignities of a system that only pretended to care. A minor traffic incident precipitated the first of what would be numerous violent revolts against the social system. The recriminations against the police and property became the hallmark of the revolt, but these were just symptoms of a long, neglected pathology." This was the beginning of the publicity, interest and activity that led to the publishing of this book. The experiences of the subsequent five years are, at least in part, indelibly imprinted upon all our memories. Beginning with the cries of a few, and culminating in the McCone and Kerner reports, traditions and attitudes of all aspects of our society have been chastised; no segment has remained immune to criticism. The health services are condemned for: disproportionate morbidity and mortality in the ghettos; the exodus of medical manpower from the inner city; inadequate financing of inner city medicine; undertrained, overworked, overpaid doctors who develop "mass production" techniques to take advantage of public aid recipients; and lack of concerned involvement of medical institutions — whether academic, organizational, or political.

These and other criticisms were brought out during panel discussions that centered around the experiences of three cities; Chicago, Newark, and Los Angeles. The staggering proportions of the problems discussed can only be fully appreciated by reading the book. One particular problem of which we should all be aware is the paucity of doctors in the inner city. The problem is compounded by the realization that the M.D.s and D.O.s remaining in the city are for the most part elderly, and in many cases not current in medical therapeutics. In toto, the caliber of care administered by this segment of the medical profession has been documented to be significantly inferior to that in other aspects of our society. But, to quote M. Alfred Haynes, project director of the National Medical Foundation, and Michael R. McGarvey, special assistant to the administrator, Health Services and Mental Health Administration, H.E.W., "these physicians whether young or old are frequently cruelly condemned, especially by university professors and teaching hospitals, as being incompetent, but there are few university professors who are either able or willing to replace these men and their contribution to the community. These professors find it much easier to curse the darkness than to light a candle."

Another question that concerned the conference at length was whether American medicine could afford to continue the "fee for service," "profit motive" attitude in the distribution of medical care. Although no definite answer was offered, it seemed to be the general consensus that the trend toward group practice, pre-paid medical care was the most efficient method of distributing care and in the best interest of all concerned. The involvement of the community and ghetto leaders both in the organizing and operating of these programs was felt to be vital to their success and to the welfare of the community.

The United States currently spends over six percent of the GNP for health services. Experts feel this

is an adequate amount to "do the job" if efficiently distributed. Yet the lack of organization makes this a grossly inadequate sum. It was felt that integrity in positions of power is demonstrably lacking and that this was one area where, with a little effort, real progress might be made.

One of the discussors pointed out that America's greatest untapped resource was the ghetto population of this nation. Largely burdened by ill health, this segment is unable to realize full potential. For example, economists have estimated that hunger and malnutrition cost the American economy $5 billion annually. It therefore becomes economically, as well as morally and ethically, imperative that all efforts be made to alleviate such poverty and ghetto conditions.

Each discussion reiterated that there is still much to be learned. Efforts are being made on many fronts to provide answers to some of the questions posed above and others that were raised in the book. With time, however, it is becoming more and more apparent that ". . . the solution to our problems in the cities is not primarily a matter of money or guns or of more law and order, but a matter of more people who care. If there are enough people who care about the plight of the ghettos the money will come, and if people do not really care, the expenditure of billions will only be wasted. . . . If the government cared, it would not merely provide money to take care of the poor and then cut it back; it would develop a meaningful health program that would provide equal access to health care for all Americans. If the universities really cared, they would restructure their priorities, doing less about the esoteric and doing more about those problems which plague our ghettos, such problems as infant mortality, hypertension, malnutrition, unwanted pregnancies, alcoholism, and drug addiction. Health professionals, if they really cared, could do a great deal to lessen the violence, create a healthy environment, and change the character of our cities. No group of people are more highly loved and respected than those who come to the aid of others in time of physical need and distress. At the same time, none are more detested than those who are false and condescending. In short, there are very few problems in the health field which could not be improved if we really cared."

The realization that doctors are fleeing from the inner city and that the physicians remaining are generally of an "inferior quality" raises the questions: What is the profile of the ghetto physician, what is (or should be) his training, and what of the future of medical education?

"A most recent study, one made in 1969 by the Harvard Medical School Commission on Relations with the Black Community, portrays him (the inner city physician in Boston) as a general practioner whose mean age is 66 years and who, in one out of two cases, is a graduate of a medical school which no longer exists." In Boston, 40 doctors serve a ghetto population of 80,000. In Cleveland, there are 0.45 physicians per 1000 persons in poor neighborhoods, as compared with 1.13 per 1000 in nonpoverty areas. Although no plans were offered as to how to attract physicians back into the city, John Holloman, chairman of Physicians Forum, offered several glimpses into the future. He envisions: comprehensive medical care administered through a unified system with an emphasis on training toward preventive medicine; the need for more primary physicians and fewer specialists; the entire cost of medical education being borne by the federal and state governments (thus increasing the obligation of future physicians to the society and its needs, and removing the insurmountable costs of medical education faced by the poor); an increase in the number and manpower output of medical schools; and hopefully, the ghetto physician of the future will become extinct because the ghetto must be eliminated.

The training programs for doctors in this country were criticized from just about every conceivable point of view. There are too few doctors turned out; the lack of sufficient experience; experience in the wrong field; teachers are unresponsive; everyone is unconcerned, etc. The criticisms were so broad ranging and all encompassing that I found it difficult to know where to begin an analysis. The discussors give the impression of not being clear in what changes need to be made, although to them it was clear that change is necessary.

As the conference progressed,

Panelists Doyle, Eaton, Holloman, and Sidel.

Editor Norman

there emerged a more positive approach to the problems that had been identified, and possible solutions to these problems were discussed. Having established the fact that two levels of medical care exist in this country, the problem at hand was how to include a population, which cannot afford to self-finance adequate medical care, into the "medical mainstream" without "demeaning social class or income differences." I think it is important to note that the conference was not so much concerned with "how are we going to get good medical care into the ghetto areas" as with "how might we provide an economic structure which would stimulate uniform medical care in all social strata?" It has recently been pointed out elsewhere that the person that is suffering most, in terms of poor medical care, is the "middle class" American. The poor are now being well cared for in clinics, and the rich can afford the private fees. But the underinsured "middle class American" has been largely ignored.

Insurance programs as presently organized are apparently inadequate. "Two-fifths of the people with family incomes of $3,000 to $5,000 are not insured. Two-thirds of people with incomes of less than $3,000 are uninsured. These figures do not include the underinsured. (e.g. In 1960, when 70 percent of all Americans had acquired some insurance against hospital costs, only 51 percent had protection that paid three-fourths or more of their bills on discharge from the hospital.)

Rashi Fein, professor of the economics of medicine, HMS, considered numerous programs and ruled out such alternatives as: physicians contributing their services; an increase in neighborhood health centers supported by the federal government; an extension of medicaid (for this would be based on the fallacious assumption that the present system of delivery of care is adequate), and an increase in the purchasing power of the poor. He favors, as did most of the conference participants, a national health insurance program. He would relate the costs of the program to the income of those covered. "The provider of the services need not — and should not — know how the costs of the policy were borne, since there should be no distinguishing characteristics that relate the coverage to the individual's income." He noted that ". . . if is most important not to think in terms of the ghetto versus the rest of society. I find it encouraging that the same proposal which would assist the ghetto can be adopted for the rest of the population."

As many who will read this article already know, Harvard Medical School has been actively involved in prepaid health care programs, and is currently administrating its own Harvard Health Plan. This plan came under considerable attack. Criticism included the manner in which the program was "imposed" on the community without prior consultation, the attitude of those administering the plan, expense, etc. Specific criticism also included the location being "too far away — not so much in distance as in sophistication and 'social territory.' " (It is located near a University campus territory to "which poor folks cannot relate.")

No one pretends to have all the answers about the systems that will cure the ills of medicine in America today. Numerous suggestions were made as to what could be done to improve the quality of the care. The speakers began with the assumption that the present systems for both the delivery of care and payment for care were currently and potentially inadequate. Subsidization of costs of medical care for the poor is now a federal law through Title XIX, but the failure of some states to implement the program, the uneven and changing eligibility in some states, the welfare stigmata often associated with the program, the unexpectedly high costs, and even more important, the failure of this program to stimulate new types of delivery programs that provide accessible care, that reach those most in need, and that provide patient and provider satisfaction, have limited its usefulness. Perhaps the greatest defect in the current system is that alternative choices are not available to the population. It is probable that there will always be individual preference and differences in patients and providers. A good system should have some choice in alternative methods or systems of care. Robert Haggerty, professor and chairman of the department of pediatrics, University of Rochester School of Medicine and Dentistry, felt that there was little data to support one type of program over another, but suggested three general criteria for programs of medical care: they should be able to be changed as experience and changing social and medical conditions warrant; the new programs should be so designed that they can be evaluated by purposeful, planned demonstrations; some of these programs should be linked to teaching programs in order that new personnel be brought in and in turn stimulate change of programs.

Joseph T. English, administrator of the Health Service and Mental Administration, H.E.W., discussed the O.E.O. concept of the Neighborhood Health Center. O.E.O. has now invested hundreds of millions of dollars in these centers, but he notes that the success or failure of these projects is dependent not upon how much money, either federal or private, is poured into a project, but upon the level of interest and energy a community is willing to put into the project. Here then, we have another criterion — those being served must be actively interested. It has become the concept of the O.E.O. that "health projects are not

neighborhood health centers, but a principle of comprehensive health services derived from the needs of the people they serve."

Senator Edward Kennedy was able to offer a perspective on the role and responsibility of government in furnishing health care. From his view, the most tragic aspect of medical care in the ghetto is the unkept promises of the federal government. ". . . our national priorities are out of joint." He listed six areas where the Congress should take action, and encourage the health leaders in public and private life to form a constituency, strong enough to secure the restructuring of our health priorities that we so urgently need: 1) We must restructure our federal health facility assistance program to ensure adequate facilities for those in need. 2) We must fund a major expansion of our overall health training programs. 3) We must expand our child and maternal care programs in the ghetto. 4) We must increase the range and efficiency of health services in the ghetto. 5) We must increase the mobility within the health professions. 6) We must bring more health students into the ghetto. (Here he placed the primary responsibility on the medical schools.) He concluded by noting that "we already possess the technology and resources to accomplish our goals of comprehensive health care for all Americans. What we need is the will." In the words of Arnold Toynbee — "the twentieth century may be best remembered as the first age in history in which people have thought in practical terms to make the benefits of civilization available for the whole human race."

One of the major themes repeated throughout the conference was that the community must be involved in the planning and direction of any programs which affect the community. The value of ". . . such involvement, representative participation and the democratic process is unimpeachable. But the virtues of such mutualism only accrue when the participating agents scrupulously place the benefits to their constituency above all other considerations. Unfortunately, community participation today, all too often, falls prey to the self-serving ambitions of would-be leaders on one side, or the undoing indulgence of unseasoned or inept medical practitioners on the other."

Saul D. Alinsky, executive director, Industrial Areas Foundation, Chicago, pointed out that the development of power among the poor should be welcomed instead of feared by the nonpoor. "The issue which is not clear to organizers, missionaries, doctors, educators, or any outsider is simply that if a people feel there is nothing they can do about a bad situation, that they do not have the power to change it, then they do not think about it — Why start figuring out how you are going to spend a million dollars if you do not have a million dollars or are never going to have a million dollars. However, once a people are organized so that they have the power to make changes when confronted with questions of change, they begin to think and to ask questions about how to make the changes. Perceptive questions begin to arise, and it is then that people have a genuine opportunity to act and to change conditions, then that they have it within them to think their problems through, that they are competent, that they will raise the right questions, that they will seek special professional counsel and look for the answers. Then you begin to realize that believing in people is not just a romantic myth."

Leonard W. Cronkhite Jr. '50, general director, Children's Hospital Medical Center, Boston, however, points out that personal involvement in efforts to operate or organize "ghetto medicine" is not always a benign and enjoyable undertaking. "The physician-administrator must recognize that to translate his commitment into real change he must suddenly become highly visible in a highly volatile milieu. Unfortunately, high visibility produces heightened vulnerability, so that he must expect, as a matter of course, such unpleasant phenomena as harassment, verbal abuse, and public accusation, no matter how right he may believe his cause to be.

The very young — medical students, residents, nurses, recent graduates in social work, and the like — are perhaps the most vulnerable to the phenomenology of today's sweeping change. They enter the ghetto often with the most compassion, the most concern, and the highest motivation to achieve basic equality. They also bring the least experience, the most naiveté, and the most easily fractured egos. When they are turned away by the community they are dismayed by their inability to transmit their concern and the depth of their conviction to those around them."

The community elders have an obligation to their young that are beset with feelings of inadequacy, impatience, and frustration. They must listen to these young people and consider carefully what they have to say. Yet, at the same time, as responsible adults and administrators, the community elders must draw the line when no more concessions are possible without jeopardizing the quality of patient care. They must do so even when it reflects unfairly on the establishment or when their valid reasons may be deliberately misinterpreted. For despite claims to the contrary, "there are no shortcuts to achieving professional competence, and anything short of professional competence would continue to cheat the community."

The reader should find this an informative, interesting and stimulating book. I was disappointed at the lack of apparent definitive suggestions, plans or programs. The book, however, offers us all an opportunity to gain insight into a problem from which most of us divorce ourselves, yet one which daily affects each of our lives. The devastating problem of the ghetto will only be solved when we as individuals care; and one has to be aware and understand before he can care.

ROBERT W. BEART, JR. '71